# STATE TITLE V BLOCK GRANT NARRATIVE
# STATE: NC
# APPLICATION YEAR: 2006


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# I. GENERAL REQUIREMENTS

## A. LETTER OF TRANSMITTAL

The Letter of Transmittal is to be provided as an attachment to this section.

## B. FACE SHEET

A hard copy of the Face Sheet (from Form SF424) is to be sent directly to the Maternal and Child Health Bureau.

## C. ASSURANCES AND CERTIFICATIONS

Assurances and certifications will be maintained on file in the Women's and Children's Health Section Office, located in Room 510, 1330 St. Mary's Street, Raleigh, NC.

## D. TABLE OF CONTENTS

This report follows the outline of the Table of Contents provided in the "GUIDANCE AND FORMS FOR THE TITLE V APPLICATION/ANNUAL REPORT," OMB NO: 0915-0172; published June, 2003; expires May 31, 2006.

## E. PUBLIC INPUT

Public input on the MCH Block Grant will be obtained by posting it on WCHS website in July and asking partnering agencies (including Healthy Start Foundation, March of Dimes state chapter, Area Health Education Centers, etc.) to review it and provide feedback to the Section Office.

## II. NEEDS ASSESSMENT

In application year 2006, the Needs Assessment must be provided as an attachment to this section.

## III. STATE OVERVIEW

### A. OVERVIEW

In North Carolina, governmental health and social services are generally administered through autonomous county-level governmental agencies. This decentralized structure poses special challenges for design and implementation of statewide programs and initiatives. Priority-setting, decision-making and problem-solving within the Title V program routinely involves use of the extensive network of state-level interagency working groups, and the input of public health workers (and others) at the local and regional level. The Title V Program is housed in the Women's and Children's Health Section (WCHS) in the Division of Public Health (DPH), which is found in the NC Department of Health and Human Services (DHHS).

Managed care organizations (MCOs) are increasingly important service providers for populations with private health insurance. Although the use of MCOs for delivery of services to Medicaid recipients was implemented in a deliberate fashion, the shift from public to private sector provision of services to the low income population has had a profound impact on local public health agencies who have traditionally served as direct providers of publicly-subsidized primary and preventive health services. The emphasis on public-private partnerships is strong across the state, as "interested parties" determine what services are needed, and who can best provide them. The role of the state agency is to create and maintain state level partnerships, and to provide leadership and consultation to local decision-makers.

According to 2000 census data, the total state population has grown to 8,049,313, a 21.4% increase from 1990 census data. African-Americans remain the largest racial/ethnic minority group in the state, however the Hispanic/Latino population has increased over 300% from a reported 1.04% in 1990 to 4.7% in 2000. Based on 1997 poverty threshold information, 12.6% of North Carolinians live below the poverty level, with 18.6 percent of children living below the poverty level. The median household income for North Carolina in 1997 was $35,320, while the national average was $37,005. The unemployment rate for 2000 was 3.6%. In 2000, seventy-nine percent of the population over 25 years of age had graduated from high school, while 23% were college graduates. Further demographic data are available in the core and developmental Health Status Indicator forms found in Sections 5.4 and 5.6.

The NC DHHS is the largest agency in state government and is responsible for ensuring the health, safety and well being of all North Carolinians, providing human service needs to populations with mentally illness, deafness, blindness and developmental disabilities, and helping poor North Carolinians achieve economic independence. The Department has more than 19,000 employees and is divided into 24 divisions and offices which fall under four broad service areas - administrative, support, health, and human services. Three divisions account for most of the department's budget. These are the Division of Medical Assistance (which houses the Medicaid program), the Division of Social Services, and the Division of Mental Health, Developmental Disabilities and Substance Abuse Services. Additional divisions are the following: Aging; Budget, Planning, and Analysis; Child Development; Facility Services; Human Resources; Information Resource Management; Public Health; Services for the Blind; Services for the Deaf and Hard of Hearing; and Vocational Rehabilitation. The department is also responsible for managing the town of Butner. DHHS Offices include: Department Controller; Council on Development Disabilities; Economic Opportunity; Education Services; Internal Auditor; Legal Affairs; Property and Construction; Public Affairs; and Research, Demonstrations, and Rural Health Development. DHHS also oversees 19 facilities, including psychiatric hospitals, schools for the Deaf, and alcohol and drug abuse treatment centers. Direct health and social services are generally administered through autonomous county-level governmental agencies. There are 85 county or district Local Health Departments (LHD) providing health services for the one hundred counties that comprise North Carolina, as well as 100 county Departments of Social Services. This decentralized structure poses special challenges for design and implementation of statewide programs and initiatives. Priority-setting, decision-making and problem-solving within the Title V program routinely involves use of the extensive network of state-level interagency working groups, and the input of public health workers (and others) at the local and

regional level.

The current DHHS Secretary, Carmen Hooker Odom, was appointed in January 2001. During her tenure, the Secretary has identified the following four top priorities for the Department: 1) improving and expanding early intervention services to infants and toddlers; 2) improving long-term care for the elderly and for people with disabilities; 3) reforming the state mental health system; and 4) eliminating health disparities. While all of these priorities impact the work performed by the staff of the Women's and Children's Health Section (WCHS), the most direct impact is felt by priorities one and four.

The NC Infant-Toddler Program, through the Early Intervention (EI) Branch, WCHS, DPH is the state lead agency for Part C of the Individuals with Disabilities Education Act (IDEA). The program completed its reorganization as of July 2004 with the eighteen Children's Developmental Services Agencies (CDSAs) serving as local lead agencies. Over two hundred new employees have been hired by the CDSAs to carry out their new service coordination role and to meet other oversight responsibilities. Early intervention services are being provided through contracts (approximately 400) with public and private agencies, organizations, or individuals. Regional Interagency Coordinating Councils and Local Interagency Coordinating Councils are carrying out their roles as advisory partners to the CDSAs as outlined in the Early Intervention Design Plan.

One of the specific values of the EI Reorganization is that of "easy access to services for families". Beginning July 1, 2004, all referrals are made directly to the CDSAs. The new, streamlined system for referral has worked well. The greatest challenge to timely evaluation of infants and toddlers at the present time is the increase in demand for EI services (reflected in a marked upsurge in referrals) combined with the lack of additional resources to meet the needs of these families. During FY04, there were 4719 infants and toddlers referred to the early intervention program. In the first six months of FY05 (July-December), there were 8144 infants and toddlers referred, which demonstrates a marked increase from previous years. In FY04, the total number of infants/toddlers enrolled in EI (10,978) plus the total number of preschoolers evaluated (6308) was 17,286. While this represents a slightly smaller total number of children served than in some previous years, this is a result of the program's increased emphasis on services for infants and toddlers, for whom the program is required to provide a wide range of services. Services for preschoolers, on the other hand, have been predominantly one-time evaluations, so service provision to infant/toddlers is more resource-intensive.

Several federal mandates have had a significant impact on the early intervention system and have broadened the opportunity for service provision to more children with comprehensive health care needs. The Child Abuse and Prevention Treatment Act (CAPTA), originally enacted in 1974, was most recently amended in the Keeping Children and Families Safe Act of 2003. CAPTA now stipulates that children under three years of age with substantiated abuse and neglect be referred to early intervention. North Carolina began this referral process in July 2004. The Infant-Toddler Program in partnership with the Division of Social Services provided statewide training in order to effectively implement this mandate. The Homeless Assistance Act Amendments of 1990 added "preventative services regarding children of homeless families or families at risk of homelessness" to the CAPTA language. The Individuals with Disabilities Education Improvement Act was reauthorized and signed into law December 3, 2004. This reauthorization echoes CAPTA legislation and also requires a referral to early intervention of young children affected by substance abuse and illegal drug exposure. Estimates from the Division of Social Services are that this will result in 5000 referrals annually; the early intervention program had been serving approximately 29% of these children, so more than 3000 of these children will reflect new referrals to the program. The law specifies that state provide outreach/child find to parents of premature infants; to parents of children with other physical risk factors associated with learning or developmental problems and to homeless shelters and similar settings. In order to meet the CAPTA and IDEA requirements, the Infant-Toddler Program's many partners in the Division of Public Health are more important than ever before.

While these changes are positive in terms of the goals of the state's early intervention program, this substantial increase and the potential for additional numbers of children to be served by the program poses very significant challenges. Because of the entitlement nature of early intervention, all eligible

children must be served. The level of state funding has not increased in four years. The Infant-Toddler Program will continue to address its capacity needs over the next year by exploring additional resources, reviewing the program's current eligibility definitions, and reviewing the provision of evaluations to the preschool population.

In regards to the Secretary's fourth priority, eliminating health disparities, the WCHS collaborated with the other divisions and offices in DHHS to develop the DHHS Call to Action to Eliminate Health Disparities report. Three WCHS staff members served on the Steering Committee of Eliminating Health Disparities which developed the report. The purpose of the report is to provide a framework for understanding the magnitude of racial and ethnic disparities in NC and some of the social determinants of these disparities. The Call to Action focuses on the role of the Department in addressing these issues and provides specific action steps proposed by each division and office in the Department to address these issues. As part of the development of the report, the Disparity Program Assessment was conducted throughout the Department to examine divisions' and offices' key health disparities priority conditions or issues, service delivery and socio-cultural challenges, and health disparities focus areas. Results from the assessment in the DPH indicated a need to examine and address several socio-cultural challenges faced by numerous programs in the division, including language and communication difficulties, attitudes and values of providers and clients, and the need to improve health education/knowledge and awareness. The WCHS has developed a series of action steps incorporated into the implementation plan which fall under the nine key recommendations identified in the report. Examples of these action steps include: preparation of maternal health/family planning fact sheets on the health status inequities in NC to assist community-based organizations and other contractors to identify priority areas for health interventions; increasing the number of minorities served in the NC Early Intervention program; and documentation of best practices in serving the Hispanic/Latino community in WIC local agencies

Children in NC whose family income is under certain federal poverty levels may be eligible for either Medicaid or NC Health Choice, the State's Child Health Insurance Program (CHIP). To qualify for Health Choice, children must be uninsured, be ineligible for Medicaid, and have a family income that is equal or less than 200% of the federal poverty guidelines. This program is administered jointly by DMA and DPH, with DMA providing oversight for the program and establishing eligibility policy and DPH being responsible for outreach efforts and for services to children with special health care needs. The program first started enrolling children in October 1998. Unlike Medicaid, however, Health Choice is not an entitlement program, thus it must operate within specific budget parameters.

Despite NC's decision to implement a separate CHIP rather than a Medicaid expansion, the decision was made to do outreach and enrollment of families for both Medicaid and Health Choice in a seamless process. A range of activities to enhance the enrollment has been implemented, including a simplified 2-page application form, multiple community application sites, mail-in option, training of community professional and agency staff to assist with the application process, twelve months continuous eligibility for both programs, and availability of applications in English and Spanish. In 2001, through funding from a Robert Woods Johnson Covering Kids Project, focus groups have been conducted to propose an even more family-friendly re-enrollment process. Specific messages, graphics, and re-enrollment strategies were tested. In addition, NC continues to focus on a grassroots approach to outreach for Health Choice. Each of the 100 counties, working through the co-sponsorship of local health and social services departments, was asked to form an outreach coalition. These coalitions have been very effective in crafting outreach strategies specific to the circumstances of their individual communities and target groups. In a parallel fashion, SCHS convened a state level coalition called the Health Check-Health Choice Outreach Committee, comprised of state, regional, and local representatives from public/private agencies, health care provider organizations, and child advocates. The role of the WCHS has been to support efforts of local coalitions by providing print materials, electronic media pieces, monthly updates, consultation/technical assistance, workshops, and targeted outreach to various groups/organizations from the state level.

Due to strong interest from members of the General Assembly and among public health leadership, a Public Health Task Force was established in mid-2003 to study public health in NC and to devise an

action plan to strengthen public health infrastructure, improve health outcomes, and eliminate health disparities. Membership on the Task Force is broad and includes legislators, community leaders, public health professionals from state agencies and universities, local health directors, other healthcare providers, and representatives from minority communities. The six committees of the Task Force reflect the Task Force's six focus areas: accreditation of state and local health departments; public health structure and organization; public health funding (finance); workforce development and training; improving public health planning, resources and health outcomes; and quality improvement and accountability. The Title V director was assigned to co-chair the accountability committee and many staff members from the WCHS served on the committees. The Task Force convened four public meetings, held three regional public forums, heard testimony, and reviewed research and lessons from the field during the course of their work. An interim report was released in May 2004 and the final NC Public Health Improvement Plan to guide public health efforts in the next two to three years was released on January 15, 2005. There were two sets of recommendations in the report -- Core Infrastructure, which addresses public health system needs required to deliver the ten essential public health services and Core Service Gaps, which addresses critical needs in core public health service program areas. A copy of the Final Report can be found at the following URL: http://www.ncpublichealth.com/taskforce/docs/FinalReport1.15.05.pdf.

In addition to the work of the Public Health Task Force, staff members from WCHS continue to collaborate with staff across the Department on one of the NC DHHS Secretary's priority areas, that of eliminating health disparities. Efforts to implement the action steps developed in the Call to Action January 2003 report continue. In May 2004, the Office of Minority Health released a publication entitled "Racial and Ethnic Differences in Health in North Carolina: 2004 Update" which clearly illustrates the areas of health disparities and need for improvement in health outcomes. These areas include health insurance coverage rates, sexually transmitted disease rates, and infant mortality rates. A copy of the report is available at the following URL: http://www.schs.state.nc.us/SCHS/pdf/RaceEthnicRpt.pdf. One way in which WCHS staff have collaborated is that C&Y Branch staff were able to work with department leadership to expand the goal for health parity for people with disabilities as well as for ethnic and racial minorities. This has resulted in integration of strategies for eliminating service delivery and health disparities among children, youth and adults with disabilities in the action plans submitted by DPH programs and other DHHS divisions.

During FY04, the WCHS implemented a logic model/outcomes-oriented planning process. Earlier in FY03, the Section Management Team held a retreat and defined a consensus set of core WCH Indicators to be used to communicate the value of the work done by the WCHS with policymakers, stakeholders, and the general public. At the same time, the NC DHHS decided to implement performance-based contracting using logic models as a component of performance-based management. Thus, during FY04, the SMT members were responsible for leading work groups to create logic models for each of the eleven core indicators. Both regional and central office staff contributed to the models which are in the final draft stage. Logic models are by design a work in progress that can be revised as necessary to more clearly and correctly depict causal relationships and integrate program activities. The Section plans to work within the framework of the current logic models over the next fiscal year and review and revise them as necessary in the spring of 2005. Certainly the results of the needs assessment might dictate changes to the inputs and outputs of the logic models. The WCHS Core Indicators are as follows:
1. Reduction of Infant Mortality
2. Improved Health of Women of Childbearing Age
3. Prevention of Child Deaths
4. Elimination of Vaccine-Preventable Diseases
5. Increased Access to Care for Women, Children, and Families
6. Prevention of Birth Defects
7. Improved Health of Children with Special Needs
8. Improved Healthy Behaviors in Women and Children and Among Families
9. Healthy Schools and Students who are Ready to Learn
10. All Newborns Screened for Genetic and Hearing Disorders

11. Provision of timely and comprehensive early intervention services for children with special developmental needs and their families.

## B. AGENCY CAPACITY

The Women's and Children's Health Section (WCHS) is comprised of five Branches, Children and Youth (C&Y Branch), Early Intervention (EI), Immunization, Women's Health (WHB), and Nutrition Services. The Section Management Team, which is comprised of the Chief, Business Operations Manager, and five Branch Heads, meets weekly to facilitate joint planning, to keep key staff informed of current activities and issues, and to plan short and long term strategies for addressing current issues. A similar process occurs within the Branches which are responsible for assessing and responding to the needs of its target population(s). In addition, once a month additional senior and middle managers meet as part of the Expanded Management Team to discuss issue such as management and leadership skill enhancement and cross-cutting Section issues such as local agency monitoring and data utilization.

Statutes
State statutes relevant to Title V program authority are established for several programs administered by WCHS. These statutes include:

GS130A-4.1. This statute requires the NC Department of Health and Human Services (NCDHHS) to ensure that LHDs do not reduce county appropriations for local maternal and child health services because they have received State appropriations and requires that income earned by LHDs for maternal and child health programs that are supported in whole or in part from State or federal funds received from NCDHHS must be used to further the objectives of the program that generated the income.

GS130A-124. This statute requires NCDHHS to establish and administer the statewide maternal and child health program for the delivery of preventive, diagnostic, therapeutic and habilitative health services to women of childbearing years, children and other persons who require these services. The statute also establishes how refunds received by the Children's Special Health Services Program will be administered.

GS130A-125. This statute requires NCDHHS to establish and administer a Newborn Screening Program which shall include, but not be limited to, the following: 1) development and distribution of educational materials regarding the availability and benefits of newborn screening, 2) provision of laboratory testing, 3) development of follow-up protocols to assure early treatment for identified children, and provision of genetic counseling and support services for the families of identified children, 4) provision of necessary dietary treatment products or medications for identified children as indicated and when not otherwise available, and 5) for each newborn, provision of screening in each ear for the presence of permanent hearing loss.

GS130A-127. This statute requires NCDHHS to establish and administer a perinatal health care program. The program may include, but shall not be limited to, the following: 1) prenatal health care services including education and identification of high-risk pregnancies, 2) prenatal, delivery and newborn health care provided at hospitals participating at levels of complexity, and 3) regionalized perinatal health care including a plan for effective consultation, referral and transportation among hospitals, health departments, schools and other relevant community resources for mothers and infants at high risk for mortality and morbidity.

GS130A-129-130. These statutes require NCDHHS to establish and administer a Sickle Cell Program. They require that LHD provide sickle cell syndrome testing and counseling at no cost to persons requesting these services and that results of these tests will be shared among the LHD, the State Laboratory, and Sickle Cell Program contracting agencies which have been requested to provide sickle cell services to that person. In addition, these statutes establish the Council on Sickle

Cell Syndrome, describing its role and the appointments, compensation, and term limits of the council members.

GS130A-131.8-9 These statutes establish rules regarding the reporting, examination, and testing of blood lead levels in children. Statutes 131.9A-9G include requirements regarding the following aspects of lead poisoning hazards: 1) investigation, 2) notification, 3) abatement and remediation, 4) compliance with maintenance standard, 5) certificate of evidence of compliance, 6) discrimination in financing, 7) resident responsibilities, and 8) application fees for certificates of compliance.

GS130A-131.10. This statute establishes the manner of disposition of remains of pregnancies.

GS130A-131.15. This statute requires NCDHHS to establish and administer an Adolescent Pregnancy Prevention Program. The statute describes the management and funding of the program including the application process, proposal requirements, operating standards, criteria for project selection, schedule of funding, and funding limitations and levels.

GS130A-131.16-17. These statutes establish the Birth Defects Monitoring Program within the State Center for Health Statistics. The program is required to compile, tabulate, and publish information related to the incidence and prevention of birth defects. The statutes require physicians and licensed medical facilities to permit program staff to review medical records that pertain to a diagnosed or suspected birth defect, including the records of the mother.

GS130A-131.25. This statute establishes the OWH in an effort to expand the State's public health concerns and focus to include a comprehensive outlook on the overall health status of women. The primary goals of the Office shall be the prevention of disease and improvement in the quality of life for women over their entire lifespan.

GS130A-134. This statute establishes the list of communicable diseases and communicable conditions to be reported.

GS130A-152-157. These statutes establish how immunizations are to be administered, immunization requirements for schools, child care facilities, and colleges/universities, and when and how medical and religious exemptions may be granted.

GS130A-371-374. These statutes establish the State Center for Health Statistics within NC DHHS and authorize the Center to 1)collect, maintain and analyze health data, and 2) undertake and support research, demonstrations and evaluations respecting new or improved methods for obtaining data. Requirements for data security are also found in the statutes.

GS130A-422-434. These statutes establish the Childhood Vaccine-Related Injury Compensation Program, explain the Program requirements, and establish the Child Vaccine Injury Compensation Fund.

GS130A-440-443. These statutes require health assessments for every child in this State entering kindergarten in the public schools and establish guidelines for how the assessment is to be conducted and reported. Guidelines for religious exemptions are also included.

Services For Pregnant Women

WCHS supports a statewide network of 85 LHD clinics which provide prenatal services to women in all 100 counties. These clinics have a long-standing commitment to the provision of multidisciplinary perinatal services including medical prenatal care, case management, health education, nutrition counseling, psychosocial assessment and counseling, and postpartum services. A wide range of preventive health services are offered in virtually all of the LHDs, allowing most clients to receive a continuum of reproductive health services at a single site. Standards for provision of WCHS supported prenatal and postpartum services are based on the American College of Obstetrics and

Gynecology (ACOG) guidelines. These standards have been revised to be consistent with best practices derived from the current scientific literature as well as with the relevant NC regulations and are provided in the Maternal Health Resource Manual. They are also generally quite consistent with the new fourth edition of the American Academy of Pediatrics/American College of Obstetricians and Gynecologists' Guidelines for Perinatal Care. Because of this consistency with these nationally recognized guidelines, there is a good case to be made that these standards should also provide the basis for standards for the prenatal care provided by Medicaid managed care and ultimately commercial managed care agencies. The accountability tool developed from these standards could form the kernel of an accountability system for Medicaid and commercial managed care services. Consultation and technical assistance for all contractors is available from WCHS staff members with expertise in nursing, social work, nutrition, health education and medical services. Staff includes regional nursing and social work consultants who routinely work with agencies within assigned regions. In order to achieve the WCHS goal of risk-appropriate prenatal care, the Section also supports 18 high risk maternity clinics (HRMCs) across the state. The "traditional" HRMCs, located at tertiary care centers, are supervised by Maternal-Fetal Medicine specialists with immediate access to state-of- the-art technical support services and subspecialty consultation. These clinics have true regional catchment areas and function as "end providers." They are equipped to handle the highest risk prenatal clients without need for referral to higher levels of care. The remaining HRMCs are housed in larger health departments, and are generally staffed by local obstetricians. They do not draw from a regional catchment area and refer the highest risk clients to the tertiary centers for care. At the time of the inception of the HRMC program, the LHD HRMCs were pioneers in the provision of multidisciplinary care and also filled in some gaps where intermediate level care was somewhat inaccessible. As time has passed, the multidisciplinary care model they pioneered has been widely adopted, at least in the public sector, and the tertiary center network in the State has matured. The future role of these "intermediate level" HRMCs is unclear. As part of its charge to provide technical assistance and oversight to this network of clinics, WCHS continues to assess what changes are needed in the program to achieve the goal of risk-appropriate services for all pregnant women.

Maternity Care Coordination-Maternity Care Coordination (MCC) is the cornerstone of the state's attempts to eliminate barriers to prenatal care service provision. MCC services are provided by a nurse or a social worker whose primary role is to help clients access and effectively utilize services that address medical, nutritional, psychosocial and resource needs, while providing emotional support. The majority of MCCs are based in LHDs, but an increasing number are being based in private prenatal provider offices. WCHS provides start-up funding to local providers of support services to encourage them to hire additional care coordinators in order to increase the percentage of Medicaid clients who receive care coordination. WCHS also administers a limited amount of state appropriations which categorically support the provision of care coordination services to clients ineligible for Medicaid. LHDs are free to allocate portions of the block granted federal and state funds they receive to provide MCC or other support services to clients ineligible for Medicaid.

Maternal Outreach Worker Program-The Maternal Outreach Worker (MOW) program grew out of the state's experience with the MCC program. MCCs, who are trained professionals working primarily in clinic settings, had only limited time to address the social and emotional support needs of many of their clients. It was felt there was a need for community-based services provided by women with strong community roots. MOWs are paid, trained paraprofessionals who work under the supervision of an MCC and function in some respects as an MCC-extender. The MOW functions as a problem solver, assessing each client's needs and working with the client to address those needs, adopt healthy behaviors, and avoid unintended pregnancies postpartum.

Infant Mortality Reduction Programs - In 1994, the NC General Assembly appropriated $750,000 annually to fund projects that demonstrate ways to lower infant mortality and low birthweight rates among minority populations. The Minority Infant Mortality Reduction Project (MIMRP) currently supports l5 projects for an average of $50,000 per year for up to three years. These projects address the two-fold disparity in infant mortality rates between whites and non-whites through many initiatives, including education, community development and awareness, lay health advisors, and other outreach efforts. MIMRP was conceived as primarily a demonstration project, so the numbers of persons

served by the program may not be great enough to impact statewide performance measures. The MIMRP is a joint initiative of WCHS, the Office of Minority Health and the Healthy Start Foundation.

The Targeted Infant Mortality Reduction (TIMR) program was established by the General Assembly in 1989 to provide funding that would improve the perinatal care systems in high "attributable risk" counties in the state (i.e., counties with high numbers and rates of infant mortality). Although recipient counties have substantial flexibility in the use of these funds, most of the $306,000 annual appropriation is used to support enabling services. Counties have expanded outreach efforts in maternity and family planning clinics, provided transportation and child care services for clients, and provided enhanced follow-up of persons with positive pregnancy tests and missed prenatal care appointments.

During FY98, the WCHS received the first year of funding for the federal Healthy Start grant, Eastern Healthy Start Baby Love Plus (HSBLP). The goals of this project are to reduce infant morbidity and mortality in the seven county project area in eastern NC by incorporating three models to: support and empower a community-based consortium; provide outreach and case finding services; and to provide facilitating services which will reduce barriers to accessing services. community-based organizations to also develop local programming to address infant mortality and morbidity in their community. Funding for the Eastern HSBLP project continued in FY00 and funding for an additional Healthy Start initiative, the Triad HSBLP project, began. The Triad HSBLP project focuses on the racial/ethnic disparities in perinatal health in two of the state's more urban counties, Forsyth and Guilford. The four funded models being implemented are community-based consortium, case management, enhanced clinical, and outreach/client recruitment. Also funded in FY00 was a planning grant for the Northeastern HSBLP program. This grant resulted in FY01 funding for a Healthy Start initiative in five rural, underserved counties in northeastern NC. Its focus is to improve African-American perinatal health primarily and Native American/American Indian perinatal health secondly. As of May 2005, the WHB is waiting to hear whether the Triad site has be re-funded for another grant cycle. The NE site will begin year 2 of 4 in round two on June 1, 2005. The Eastern site is in its 4th year of a 4 year cycle - round two. It is slated to end on January 31, 2006, with a new competitive grant application due sometime in August 2005.

Child Health Services

WCHS provides preventive health services to children from birth to 18 years of age primarily through LHD clinics. The schedule of recommended visits is based on American Academy of Pediatrics guidelines. Normally, clinic services are not provided for acutely ill children, although some health departments do provide pediatric primary care. Nurse screening clinics are conducted by public health nurses in LHDs. Physicians do not staff these clinics; however, services are provided under the guidance of the physician who attends the pediatric supervisory clinic. Medical management includes written policies and procedures that are updated regularly. Public Health Nurse Screeners receive specialized training for this role through a training program sponsored by the C&Y Branch. Nurse screening clinic services include: parental counseling regarding good health, nutrition practices and developmental milestones; immunizations; assessment of proper growth, development, hearing, vision, and speech; screening for anemia and lead; and referrals as needed. Pediatric clinics are conducted by physicians (family practitioners and/or pediatricians), nurse practitioners, and/or physician assistants. They serve as referral clinics for children with problems identified in nurse screening clinics. Pediatric clinic staff make referral for specialty consultations as needed.

The purpose of the Health Check program is to facilitate regular preventive medical care and the diagnosis and treatment of any health problem found during a screening for children eligible for Medicaid and under the age of 21. Health Check Coordinators (HCC) play a vital role in outreach efforts and assuring that Medicaid recipients access preventive health screenings. The HCC use an Automated Information and Notification System (AINS) to track and follow Medicaid eligible children. This system has the ability to generate personalized reminder and missed appointment letters based on paid claims data. The HCC make direct contact with clients via telephone calls, additional personalized letters, and occasional home visits. The type and results of their contacts are recorded

in the comment section of the database. They work closely with the managed care representatives at local departments of social services to ensure children are connected with their primary care provider for continuity of care. In addition, they work closely with the provider community to ensure children receive regular preventive health care and follow-up for conditions that have been referred to a specialist.

NC Health Choice for Children, the child health insurance program in NC, is a federal and state partnership to provide comprehensive health insurance to uninsured children. It provides free or low cost health insurance to children whose families cannot pay for private insurance and who do not qualify for Health Check. Children with special health care needs are eligible to receive additional benefits under NC Health Choice. This program is administered jointly by DMA and DPH, with DMA providing oversight for the program and establishing eligibility policy and DPH being responsible for outreach efforts and for services to children with special health care needs. Outreach to potentially eligible families is coordinated by Outreach Coalitions in each county. WCHS supports the efforts of the local coalitions by providing tools such as print materials, electronic media pieces, monthly coalition updates, consultation and technical assistance, workshops, and outreach to state and regional organizations.

School Health Matrix Team (SHMT) - The SHMT was created in FY04 in order to formalize a system by which all DPH staff working to improve the health status of students will be able to work together to develop unified plans and activities to work with students and schools. It is hoped that this streamlined effort will maximize the Division's school health resources and more efficiently meet the students' health needs. Membership of the SHMT is made up of DPH staff whose key work responsibilities involve working with schools. This structure brings together four DPH Sections and nine Branches and Units. One direct impact of this new structure is the change in the role of the state public health dental hygienists, who will be cross-trained on a broad range of school health topics and will be collaborating with local school nurses and other school health professionals. The SHMT works in a framework based upon the Centers for Disease Control and Prevention (CDC) eight component model of school health, also referred to as a Coordinated School Health Program. The SHMT will collaborate closely with the Department of Public Instruction (DPI), with the Senior Advisor for Healthy Schools serving as a member of the SHMT.

During FY04, the C&Y Branch worked with the NC Pediatric Society, the state Medicaid agency, LHDs and other partners to institute changes in procedures for developmental screening for all children. The following procedures were implemented for LHDs in July 2004:
- WCHS adopted the July 2001 statement of the American Academy of Pediatrics on Developmental Screening which includes specific instruments and periodic schedules that are recommended for evidence-based, formal developmental screening of children. Where there is concern about developmental status due to screening results or parental/provider concern, the child would be followed through second level screening or, if indicated, referred as soon as possible for in-depth testing/evaluation.
- Children should be screened with a formal, standardized developmental screening instrument at a minimum of 6, 12, and 18 to 24 months and 3, 4, and 5 years of age at well child visits.

The Specialized Services Unit worked with a logic model planning process to develop the following intermediate outcomes related to developmental screening:
Children will be screened early and continuously for special health care needs as measured by:
- % of infants whose mothers began prenatal screening in the first trimester
- % of infants and families monitored for special health care needs and developmental delays
- % of children receiving age appropriate well-child checks
- % of children receiving follow-up due to failed screening (vision, hearing, developmental, behavioral, mental health, oral health, metabolic)

Effective July 2004, DMA will implement policy requiring physicians who perform EPSDT well-child check-ups to use standardized assessment tools to perform developmental screening. These changes will also require the entry of a separate CPT code to indicate that the screen was conducted.

Another major focus area for the C&Y Branch has been to build the capacity of primary care providers to provide quality preventive mental health services to children and families. Plans include offering training to practices on ways to incorporate behavioral health screening and appropriate interventions as part of their core service provision. Specific steps include:
-Work with existing communities that have developed successful models for information dissemination;
-Provide intensive work with individual practices to successfully integrate behavioral health services into their workflow;
-Coordinate collaborative calls among providers for information exchange on successful intervention strategies;
-Identify quality improvement teams from model practices to meet regularly to discuss issues identified within practices, develop possible solutions, and disseminate that information to practices involved in performance improvement;
-Develop and disseminate referral network information to providers specific to their community; and
-Educate referral resources on the need to provide feedback information to the referring physician.

Services for CSHCN

Children's Special Health Services (CSHS) is a state-administered program, financed by both federal and state funds. Care is provided through a network of professionals in the private section, clinics, hospitals, schools, and community agencies. All aspects of patient care are addressed, including assessment, treatment, and follow-up. CSHS provides cardiology, neurology, neuromuscular, oral-facial, orthopedic, myelodysplasia, speech/language and hearing services. In addition to providing diagnostic and treatment services through CSHS-sponsored clinics, the program also reimburses limited services for eligible children on a fee-for-service basis. Covered services include hospitalization, surgery, physicians' care, laboratory tests, physical, occupational and speech therapy, medication, durable medical equipment, orthotics and prosthetics, medical supplies and other interventions. "Wrap-around" Services. In addition to specialty clinic services, selected "wrap-around" services are funded for Medicaid-eligible children on a fee-for-service basis. CSHS is reimbursed by Medicaid for provision of most of these services, which include hospitalization; physicians' care; laboratory tests; physical, occupational and speech therapy; medication; durable medical equipment; orthotics and prosthetics; medical supplies; and other interventions.

FY03 was a year of deep reflection and change for the CSHCN program. The WCHS continues to be committed and guided by the key principles of comprehensive, community based, coordinated and family-centered care. There have been dramatic changes at the state and community level among key collaborators such as Early Intervention, Mental Health/Substance Abuse/Developmental Disability, School Health, and the private and public health care financing and delivery system, as well as significant shifts in priorities and resource allocation in DPH. In response, the CSHCN program has continued to review and critically evaluate all aspects of the program. The process has been directed by key personnel within CSHCN, in conjunction with a strengthened Family Advisory Council, the Commission for Children with Special Health Care Needs, and other representatives from key constituency groups. Driven by considerations to improve the efficiency and effectiveness of services, while concurrently developing strategies reflective of a family-centered approach, the CSHCN program is being reorganized both centrally and regionally in WCHS, as well as in relation to community partners. The early evidence is that this will result in improved collaboration and coordination. Of equal importance, the objective to better integrate services and supports for children with special health care needs into all aspects of C&Y Branch initiatives is being strongly pursued.

Child Service Coordination-The purpose of the Child Service Coordination (CSC) program is to identify and provide access to preventive and specialized support services for children and their families through collaboration. Children are eligible for the CSC program if they are at risk for, or have a diagnosis of developmental delay or disability, chronic illness, or social/emotional disorder. In the

CSC program, a service plan for the child/family is developed based on an assessment of the families identified strengths, needs and concerns. Coordinators work with other health and social services providers to monitor the child's development, strengthen parent-child interactions, foster family self-sufficiency, provide information about available programs and services, assist with application forms, and/or help to locate desired and appropriate resources. Follow-up contacts are required at least monthly; however, the frequency is actually based on family ability and need. Children from birth to age three who meet one of the definitions of the program Risk Indicators and children from birth to five who meet one of the definitions of the program Diagnosed Conditions are eligible. There are no income eligibility requirements for the CSC Program.

Newborn Screening Services - Universal newborn screening services have been available in NC since 1966. In 1991, provision of such services became a legislative mandate with the passage of House Bill 890 "An Act to Establish a Newborn Screening Program Within the Department of Environment, Health and Natural Resources." The State Public Health Laboratory screens all newborns born in NC for phenylketonuria (PKU), congenital hypothyroidism (CH), galactosemia, congenital adrenal hyperplasia (CAH), and hemoglobinopathy disease (e.g., sickle cell). Beginning in July 1997, screening for an array of metabolic disorders using tandem mass spectrometry technology was instituted. Timely follow-up is provided by the Genetic Health Care Newborn Screening Program on all infants with suspicious laboratory results.

Neonatal Hearing Screening - Hearing screening has been mandatory for all infants born in NC as of October 1, 1999. Screening equipment was provided to 60 birthing hospitals through a special project of WCHS. The tests are performed quickly while babies are asleep. Audiologists affiliated with C&Y Branch Speech and Hearing Teams provide technical assistance to the hospitals and also perform infant hearing screenings and diagnostic assessments for older children.

## C. ORGANIZATIONAL STRUCTURE

The NC Title V program is housed within the NC Department of Health and Human Services (DHHS) in the Division of Public Health (DPH). DHHS is a cabinet-level agency created in October 1997 when the health divisions of the Department of Environment, Health and Natural Resources (DEHNR) were combined with the existing Department of Human Resources (DHR). Carmen Hooker Odom was appointed as Secretary of the Department of Health and Human Services (DHHS) by the Governor, Mike Easley, in February 2001. Serving as State Health Director and Division Director for DPH is Dr. Leah Devlin.

The Department is divided into 24 divisions and offices which fall under four broad service areas - administrative, support, health, and human services. Divisions include: Aging; Budget, Planning, and Analysis; Child Development; Facility Services; Human Resources; Information Resource Management; Medical Assistance; Mental Health, Developmental Disabilities, and Substance Abuse Services; Public Health, Services for the Blind; Services for the Deaf and Hard of Hearing; Social Services; and Vocational Rehabilitation. The Department is also responsible for managing the town of Butner.

Offices include: Department Controller; Council on Development Disabilities; Economic Opportunity; Education Services; Internal Auditor; Legal Affairs; Property and Construction; Public Affairs; and Research, Demonstrations, and Rural Health Development. DHHS also oversees 18 facilities: Western N.C. School for the Deaf, Morganton; Eastern N.C. School for the Deaf, Wilson; Governor Morehead School for the Blind, Raleigh; Whitaker School, Butner; Wright School, Durham; Broughton Hospital, Morganton; Cherry Hospital, Goldsboro; Dorothea Dix Hospital, Raleigh; John Umstead Hospital, Butner; N.C. Special Care Center, Wilson; Alcohol and Drug Abuse Treatment Center (ADATC)-Black Mountain; ADATC-Butner; Walter B. Jones ADATC-Greenville; Black Mountain Center, Black Mountain; Caswell Center, Kinston; Murdoch Center, Butner; O'Berry Center, Goldsboro; and Western Carolina Center, Morganton.

The mission of the Department of Health and Human Services is to provide efficient services that enhance the quality of life of NC individuals and families so that they have opportunities for healthier and safer lives resulting ultimately in the achievement of economic and personal independence.

DPH is comprised of the Director's Office and six Sections. The Director's Office houses units with Division-wide impact, including:
? DPH Personnel Office (staffed by DHHS Division of Human Resources)
? Office of Chief Medical Examiner
? State Center for Health Statistics
? State Laboratory
? Vital Records

Other programs and services are operated out of the five Sections: Administrative, Local and Community Support; Chronic Disease and Injury; Epidemiology; Oral Health; Legal and Regulatory Affairs; and Women's and Children's Health.

The WCHS is responsible for overseeing the administration of the programs carried out with allotments under Title V. Kevin Ryan, Section Chief, is the Title V Program Director and Carol Tant, Children and Youth Branch Head, is the CSHCN Program Director. The mission of WCHS is to assure, promote and protect the health and development of families with emphasis on women, infants, children and youth. WCHS programs place a major emphasis on the provision of preventive health services beginning in the pre-pregnancy period and extending throughout childhood. The Section also administers several programs serving individuals who are developmentally disabled or chronically ill. As mentioned previously, WCHS is comprised of five Branches: Children & Youth, Early Intervention, Immunization, Nutrition Services, and Women's Health.

The public health system in NC is not state administered, but there are general statutes in place for assuring that a wide array of maternal and child health programs and services are available and accessible to NC residents. Using federal Title V funds and other funding sources, WCHS must contract with local health departments (LHDs) and other community agencies to assure that these services are available. There are 85 local health department clinics which provide clinic and preventive services in all 100 counties. In addition, there are many community health centers and other agencies providing services. Each contract contains a scope of work or agreement addenda that specifies the standards of the services to be provided. The public health departments, which have local autonomy, have a long-standing commitment to the provision of multidisciplinary perinatal, child health, and family planning services, including medical prenatal care, case management, health education, nutrition counseling, psychosocial assessment and counseling, postpartum services, child service coordination, well-child care, and primary care services for children.

A wide range of preventive health services are offered in virtually all of these health departments, allowing most clients to receive a continuum of reproductive health services at a single site. Standards for provision of WCHS supported prenatal and postpartum services are based on the American College of Obstetrics and Gynecology (ACOG) guidelines. These standards have been revised to be consistent with best practices derived from the current scientific literature as well as with the relevant NC regulations and are provided in soon to be published Maternal Health Resource Manual. They are also generally quite consistent with the new fourth edition of the American Academy of Pediatrics/American College of Obstetricians and Gynecologists' Guidelines for Perinatal Care. Because of this consistency with these nationally recognized guidelines, there is a good case to be made that these standards should also provide the basis for standards for the prenatal care provided by Medicaid managed care and ultimately commercial managed care agencies. Local health agencies receiving Title X funding to provide family planning services must abide by the January 2001 Program Guidelines for Project Grants for Family Planning Services developed by the Office of Population Affairs (OPA), US Department of Health and Human Services.

Consultation and technical assistance for all contractors is available from WCHS staff members with expertise in nursing, social work, nutrition, health education and medical services. Staff includes

regional child health and women's health nursing and social work consultants who routinely work with agencies within assigned regions.

In 2004, the state piloted a new program, the NC Local Public Health Accreditation Program (NCLPHAP). This program seeks to assure and enhance the quality of local public health in NC by identifying and promoting the implementation of public health standards for local public health departments, and evaluating and accrediting local health departments on their ability to meet these standards. In the first year, 6 local health departments volunteered to undergo the accreditation process as a pilot, and in 2005, four more will be evaluated. The goal of the NCLPHAP is to assure the capacity of every local public health agency in NC to perform a standard, basic level of service. The NCLPHAP does not create an entirely new accountability system; rather it links basic standards to current state statutes and administrative code and the many DPH and Division of Environmental Health (DEH) contractual and program monitoring requirements that already exist. The Division's goal is to see that instead of a voluntary process of accreditation, the NCLPHAP becomes a mandated procedure.

Organizational charts for DHHS and DPH are attached.

## D. OTHER MCH CAPACITY

The Section employs over 600staff members responsible for management and administration of programs and services for the MCH population.

Key staff members

Section Chief - Dr. Kevin Ryan replaced Dr. Ann Wolfe as Title V Director in March, 1999. He had served as Chief of the Women's Health Section (now Women's Health Branch) since 1991. Dr. Ryan graduated from the University of California at Davis Medical School and completed a residency in Obstetrics and Gynecology at the University of Arizona Health Sciences Center in Tucson, Arizona. After completing his residency in 1986, he became an Assistant Professor in the Department of Obstetrics and Gynecology and then began a private practice in obstetrics and gynecology. He completed an M.P.H. from the UNC School of Public Health, Department of Maternal and Child Health in 1991. Since his graduation he has maintained an active relationship with the Department, and has served as Adjunct Assistant and then Associate Professor.

Section Business Operations Manager - Peter Andersen assumed this position in March 2001. Mr. Andersen has a masters degree in Health Education from the University of Virginia (1976) and a masters in business administration from Delaware State University (1989). He has been in the public health field for 19 years. The first eleven were with the Delaware Division of Public Health in a variety of chronic disease program management positions. His eight years with the North Carolina state health agency have been in positions in health promotion and chronic disease prevention.

Women's Health Branch Head - Dr. Joe Holliday replaced Dr. Kevin Ryan as Women's Health Branch Head in February 2000. Dr. Holliday has over 25 years of public health leadership experience, including local health director positions in Virginia, South Carolina and North Carolina. Previous Division of Public Health duties included: program manager for the Comprehensive Breast and Cervical Cancer Control and Wise Woman Programs; and Chief of the Chronic Disease Prevention and Control Branch. He is a graduate of University of North Carolina at Chapel Hill, Vanderbilt School of Medicine, and the UNC School of Public Health (Department of Maternal and Child Health). He also completed a pediatric internship from Pittsburgh Children's Hospital and a preventive medicine residency from the School of Medicine, University of North Carolina.

Children and Youth Branch Head - Carol Tant replaced Tom Vitaglione as Branch Head in February 2000. She has an undergraduate degree in psychology, and earned her M.P.H. in health

administration from the UNC School of Public Health in 1980. She worked in increasingly responsible positions in mental health, women's health and children's health services. Carol's work experience in children's health for over 19 years has included positions in genetics, specialized services and preventive health at both the regional and state levels.

Nutrition Services Branch Head - Alice Lenihan earned a B.S. in food and nutrition from the College of St. Elizabeth (New Jersey, 1970), and a M.P.H. in health administration from the UNC School of Public Health in 1983. After gaining local and regional experience in WIC programs, she was appointed state WIC Director in 1984. She continues to serve in that capacity as Nutrition Services Section Chief. In addition to the WIC program, she has oversight of the state's Child and Adult Care Feeding Program, Summer Food Service Program, and Nutrition Education and Training Program.

Immunization Branch Head - Beth Rowe-West assumed the position of Branch Head in December 1999 after serving in an acting capacity since October, 1998. She earned her B.S. in Nursing from the University of North Carolina at Greensboro and has worked most of her career in public health, serving 11 years in a local health department prior to coming to the Immunization Branch as the Hepatitis B Coordinator in 1994.

Early Intervention Branch Head - Deborah Carroll assumed the position of Branch Head in March 2005. She received a BS in Speech Pathology from Appalachian State University, a MA in Speech Pathology-Audiology from UNC Greensboro and a PhD in Human Development and Family Studies from UNC Greensboro. She is licensed and board certified in Audiology. She worked from 1999 to 2003 in the EI Branch as Director of EI's Comprehensive System of Personnel Development. Most recently she was the Unit Manager of the Genetics and Newborn Screening Unit of the C&Y Branch of the WCHS.

Data Specialist/Needs Assessment Coordinator (State Systems Development Initiative Project Coordinator) - Sarah McCracken Cobb began working in this position on July 1, 2000. She completed her undergraduate degree in chemistry at the University of North Carolina at Chapel Hill in 1987 and earned an MPH from Boston University in 1989. After serving in the US Peace Corps, she has held assessment positions with the state health agency in HIV/AIDS, immunization, and maternal health programs.

During FY04, the C&Y Branch filled the Family Liaison Specialist position by a family member of an adolescent with special needs, Marlyn Wells. She serves as staff to the Family Advisory Council, which works extensively with the staff of the C&Y Branch. She trains, assists and advises staff on the development and promotion of family related issues and activities such as family perspectives, family centered care, care coordination, transition planning, medical home and educational/community resources. She also advises WCHS families on an as-needed basis on issues related to children with special needs.

## E. STATE AGENCY COORDINATION

With creation of the Department of Health and Human Services in October 1997, state-level public health, mental health, social services, Medicaid, child welfare, vocational rehabilitation, substance abuse, and child development programs are now administered from a single agency. The DHHS Secretary has weekly meetings of the directors of these programs. These serve as a forum for discussing common issues and for facilitating coordination of efforts. The DHHS Assistant Secretary for Health conducts regular meetings with the directors of the three divisions that he manages (Public Health; Facility Services; and Mental Health, Developmental Disabilities, and Substance Abuse Prevention) Thus, intra-agency coordination is expected and facilitated at all levels of the organization. In addition, the Division is signatory to formal written agreements with several agencies, including:
-DHHS Division of Medical Assistance for provision of Medicaid reimbursed services for the MCH population. The current agreement includes a wide array of services and defines joint responsibility for informing parents and providers of the availability of MCH and Medicaid services. This agreement

is revised in its entirety every five years, with interim changes as needed.
-Department of Public Instruction (state education agency) for assuring the provision of multidisciplinary evaluation, special therapies, health and medical services, and service coordination. This agreement is updated every three years and meets the requirements of the Individuals with Disabilities Act (PL 102-119).
-DHHS Office of Research, Demonstrations and Rural Health Development (formerly Office of Rural Health and Resource Development). The state primary care agreement outlines the Division's relationships with community health centers and other primary care providers.
-DHHS Division of Vocational Rehabilitation Under this agreement, the Division assumes responsibility for informing families of the availability of SSI, eligibility determination (when appropriate) and assurance that children remain under care.
-DHHS Division of Child Development This agreement specifies collaboration in three areas: child care health and safety training calendar; a monthly family child care health bulletin; and support for the child care health specialist position that responds to health and safety issues through the 1-800-CHOOSE1 hotline. The hotline gives access to the resource center which provides training, technical assistance and information to child care health consultants, child care providers, and consumers. WCHS also is an active member of the Advisory Committee on Public Health Issues and Child Care.

WCHS staff assure that information about health and social services is available to the target population by supporting the following toll-free information and referral hotlines:
-Family Support Network (1-800-TLC-0042) provides information about special health problems and the availability of services for children with special health care needs. (Meets IDEA requirements.)
-CARELINE (1-800-662-7030) provides general information about available social services.
-NC Family Health Resource Line (1-800-367-2229) provides information, advocacy and referrals for primary and preventive health services for children and youth and provides general perinatal information with special emphasis on reaching pre-conceptional and pregnant women. (Database linked to CARELINE.)
-CSHCN Help Line (1-800-737-3028) provides information about genetic services and services for children with special health care needs.

Division of Public Health and WCHS staff work with the state education agency (Department of Public Instruction) on a number of projects including a CDC-funded grant to improve interagency coordination of health services offered by health and education agencies (CDC "infrastructure" grant), and nutrition programs. In addition, WCHS provides leadership, consultation and technical assistance to the state education agency and local school districts for:
-Development and maintenance of school-based and/or school-linked health centers,
-Expansion and enhancement of school nurse services,
-Nutrition and related training for food service workers, and
-Implementation of USDA-funded summer food and nutrition programs.

Close working relationships are maintained with the UNC School of Public Health, particularly with its Department of Maternal and Child Health. Division staff members serve as adjunct faculty members and are frequent lecturers in the Department, in addition to serving on Departmental advisory committees. Faculty members are asked to participate in Division planning activities to provide review and critique from an academic and practice perspective.

Although local health departments operate as autonomous entities, the state health agency funds a substantial amount of their services and the Division of Public Health works closely with them in all phases of program development, implementation and evaluation.

Strong relationships between state and local agencies are maintained by the continuous efforts of WCHS staff members to involve these agencies in the development, implementation and evaluation of WCHS initiatives. WCHS staff lead or participate in state-local collaborations that include, but are not limited to the following task force, on-going, or ad hoc working groups:
-Medicaid Outreach and Education
-Health Check Initiative

-Child Fatality Task Force
-Council on Developmental Disabilities
-IDEA Interagency Coordinating Council
-Smart Start Partnership for Children (Governor's early childhood initiative)
-Coalition for Healthy Youth
-Family Preservation / Family Support Initiative
-Healthy Child Care North Carolina
-Baby Love Program (enhanced services for pregnant women and infants)
-First Step Campaign (infant mortality reduction)
-Early Intervention Intra-agency Work Group
-WCHS/Medicaid Intra-agency Work Group

Adding to the success of these efforts is the strong involvement and participation of professional agencies in Division activities. The Division works closely with the medical societies (pediatric, obstetric/gynecologic, and family practice). The Division also maintains close working relationships with other advocacy and non-profit agencies that include the NC Partnership for Children, Prevent Child Abuse NC, and the NC March of Dimes.

## F. HEALTH SYSTEMS CAPACITY INDICATORS

Data are available for all of the Health System Capacity Indicators through a variety of sources, but primarily through the State Center for Health Statistics (SCHS) from birth files, hospital discharge records, Medicaid records, linked/matched datasets, and various surveillance systems. Specific information regarding each indicator is found below.

HSCI#1 -- The rate of children hospitalized for asthma (ICD-9 Codes: 493.0-493.9) per 10,000 children less than five years of age.

The prevalence of current asthma in children is 13.9 percent (NC BRFSS 2002). NC Medicaid claims from 1997-98 provide comparable estimates with an overall prevalence for children 0-14 of 13 percent (Jones-Vessey, 2001). Trend data for this indicator is very erratic, as it has fluctuated between 81 and 61 per 10,000 children since FY95. Before FY95, the number of possible diagnoses on the hospital discharge record was five, but this increased to nine in 1995, thus giving a potential for an increased rate, which was realized. The state prevalence, hospitalization and mortality data indicate significant disparities by race/ethnicity, age, gender, and geography. In the overall population, nonwhites had a rate that was 4 to 5 times higher than whites; females were more frequently hospitalized than males; and young children, followed by seniors (over age 65), had the highest rates of hospitalization. Rural areas had higher hospitalization rates than urban areas, and eastern NC had the highest rates of any geographic region. The rate of hospitalizations was 2.75 times higher in nonwhite children (mostly African American) compared to white children. In 2000, the Asthma Alliance of NC, in collaboration with its partners, one of which is the C&Y Branch, conducted an asthma prevalence survey of 192,000 seventh and eighth graders from public schools. The NC School Asthma Survey (NC SAS) shows that 17 percent of 7th and 8th graders reported current asthma-like symptoms (wheezing) with no physician diagnosis. Results from point in time studies and ongoing asthma data collection systems continue to guide the work of the Asthma Program Manager working in the C&Y Branch and providing staff support to the Asthma Alliance of North Carolina (AANC). The State Asthma Program office has been involved in community projects such as Tools for Schools, A is for Asthma and Integrated Pest Management to reduce children's exposure to asthma triggers. In addition, the Asthma Program Manager in partnership with the AANC has plans to develop a Comprehensive State Asthma Plan aimed at reducing the burden of asthma in North Carolina. The state was recently awarded a CDC grant will allow for the addition of an epidemiologist to the C&Y asthma program staff. Grant funding will also help enhance asthma surveillance using existing Medicaid, hospital discharge, and death certificate data. Work towards incorporation of childhood and work-site asthma modules into the state BRFSS in alternating years continues and the implementation of the Child Health Assessment Monitoring Program (CHAMP) survey should also provide better data regarding

behavioral issues.

HSCI#2 -- The percent Medicaid enrollees whose age is less than on year during the reporting year who received at least one initial periodic screen.

Participation rates increased to 90% for FY04, surpassing the highest rate (89% in FY02 and FY03) since data was first reported for FY94 (69%). In addition to the total percentage increase, the denominator of Medcaid enrollees has also shown a steady increase since FY94, going from 84,093 in FY94 to 100,806 in FY04. With the initiation of the SCHIP program in 1998, there were increased outreach efforts to enroll children in the state Medicaid Program (Health Check) as well as the SCHIP (Health Choice) program. It appears that an additional benefit to this outreach is an increase in the percentage of children enrolling in Medicaid and obtaining services.

HSCI#3 -- The percent SCHIP (for NC, Health Choice) enrollees whose age is less than one year during the reporting year who received at least one periodic screen.

There was an anticipated enrollment freeze for the Health Choice program in FY03 that was called off 48 hours prior to its implementation. In FY04, for the first year since the program was implemented, there was no threat of a freeze. This added stability probably contributes to the rise in the percentage of enrolled infants receiving services. However, the numbers for this indicator are still very small and fluctuations in rates should be interpreted with caution.

HSCI#4 - The percent of women (15 through 44) with a live birth whose observed to expected prenatal visits are greater than or equal to 80 percent on the Kotelchuck Index.

The percent of women in NC receiving adequate prenatal care according to the Kotelchuck Index remained high in CY03 as the percentage was 87.5. Over the past ten years, this percentage has steadily remained in the 87% to 88% range.

The WCHS continues to focus on enhancing the service provision of the state's Baby Love Program, specifically the Maternal Outreach Worker (MOW) and Maternity Care Coordination (MCC) components. During FY04, the Baby Love Best Practice Pilot began exploring and evaluating a standardized service provision process for Maternity Care Coordination and Maternal Outreach Worker services in eleven local provider agencies. The pilot has implemented a new triaging system (risk factor screening process) and a new assessment and care planning process based on best-practice case management methods ("Pathways of Care for Maternity Care Coordination"). The intent of this new process is to focus resources and efforts on those individuals with the greatest need, and subsequently to accurately identify and effectively address those needs to improve the quality of MCC and MOW services. Making sure women are able to access prenatal care early and continually during their pregnancy remains a priority in the Baby Love program. Both the Healthy Start Bably Love Plus and the Healthy Beginnings programs continue to provide support services to pregnant women and encourage them to seek early and continuous prenatal care services. In addition, the First Step Campaign continues to promote the NC Family Health Resource Line (the MCH Hotline) and to increase public awareness about the importance of preconceptional health and prenatal care.

HSCI#5 - Comparison of health indicators for Medicaid, non-Medicaid, and all populations in the State.

Data are available for 2003 for all of these indicators except for b)infant deaths, for which only 2002 data are available. In all of the indicators, outcomes for the Medicaid population are worse than for the non-Medicaid population and the population as a whole.

HSCI#6 - The percent of poverty level for eligibility in the State's Medicaid and SCHIP programs for infants (0 to 1), children, and pregnant women.

These levels have stayed consistent since the state SCHIP program, Health Choice, began in 1998.

However, in cooperation with staff from the Division of Medical Assistance, the FPRHU is currently in the initial phase in the implementation of an 1115(a) demonstration waiver, which was just recently approved. The Medicaid waiver will extend eligibility for family planning services to all women age 19-55, and men age 19-60, with incomes at or below 185% of the federal poverty level regardless of receipt of previous Medicaid reimbursed service (pregnancy-related or otherwise). The major goal of the waiver is to reduce unintended pregnancies and improve the well being of children and families in NC. Among several objectives, two specifically target reductions in the number of inadequately spaced pregnancies and in the number of unintended and unwanted pregnancies among women eligible for Medicaid.

HSCI#7 - The percent of EPSDT eligible children aged 6 through 9 years who have received any dental services during the year.

The Division of Medical Assistance provides these data. In FY04, data from CY00 to CY02 were revised to include just those children receiving Medicaid and not those under the state SCHIP (Health Choice) plan. Thus, the data for FY99 and FY00 should not be compared to the rest of the data. The FY data are actually for the prior CY. While there was an increase from 24.4% in FY01 to 35.7% in FY04, data from future years are necessary in order to tell if this increase will continue. In 1999, the NC Institute of Medicine was asked by DHHS to convene a task force to evaluate and recommend strategies to increase dentist participation in the Medicaid program and improve the preventive services provided by Medicaid. Since the task force released its report, nine of the 23 original recommendations show indication of being implemented and some action has been taken on 61% (14) of the recommendations.

HSCI#8 - The percent of State SSI beneficiaries less than 16 years old receiving rehabilitation services from the State Children with Special Health Care Needs Program.

Since January 1, 1995, all SSI beneficiaries <16 years old have been eligible for Medicaid in North Carolina. In fact, North Carolina provides Medicaid coverage to all elderly, blind and disabled individuals receiving assistance under SSI. The NC child health insurance program (Health Choice) serves as an additional payment source for these children. The Title V program continues to assure that all SSI beneficiaries receive appropriate services. Each month, WCHS receives approximately 300 referrals of newly eligible SSI children. These children are referred to Child Service Coordinators who provide the family with information about available resources, including early intervention and Title V services, and offer additional assistance as needed.

HSCI#9(A) - The ability of State to assure MCH Program Access to policy and program relevant data/information.

It is fortunate for WCHS that the SCHS has a long history of linking data with infant birth certificates; thus, WCHS can answer all but one category with 3, that the agency always has this ability. The one data linkage that does not presently occur is that of birth records and newborn screening files. Currently, the Vital Records System Automation Project is underway which will probably move the Electronic Birth Certificate system from a DOS based system to a web based system which should make a future linkage with birth records possible.

HSCI#9(B) - The ability of States to determine the percent of adolescents in grades 9 through 12 who report using tobacco products in the past month.

North Carolina has also participated in the Youth Tobacco Survey sponsored by the Centers for Disease Control and Prevention (CDC) since 1999. This biennial survey provides data on many topics, including type of tobacco use, age of initiation, media awareness, youth access, and cessation behavior. The final data from the 2003 survey show that among middle school students there has been a 38% decrease in cigarette use (from 15.0 in 1999 to 9.3 in 2003), but among high school students current tobacco use has remained about the same between 1999 and 2003 at 27.3%. There was a very high response rate among the schools and students participating in the survey in 2003,

and there were over 6000 middle and high school students who responded from 216 schools in 87 school districts. North Carolina also participated in the Youth Risk Behavior Survey (YRBS) in 2001 and 2003 which provides further information about tobacco use in teens.

HSCI#9(C) - The ability of States to determine the percent of children who are obese or overweight.

In addition to YRBS data on obesity and overweight, WCHS has instituted a Nutrition and Physical Activity Surveillance System (NC-NPASS) which provides data on body mass index (BMI) and health behaviors on children who have received child health or WIC services at a local health department or a school-based health center. One of the three primary components of the CDC grant-funded Healthy Weight Initiative in NC is to enhance this system and identify methods to increase the number of children included in the system. During FY04, much work was done to enhance a screen on the health information system used by local health departments in order to collect variables from a physical activity and nutrition behaviors questionnaire being used in local health departments to monitor trends. A working group which included DPH epidemiologists, UNC-CH faculty, nutritionists, and physical activity specialists developed the questionnaire. This group conducted a literature review for behavioral determinants of weight and then a national search for tested, validated questions on selected behaviors. The questions were then piloted in some local health departments and revisions made accordingly. The new data entry screen was made available to local health departments in July 2004, however, the screen has not been used by many organizations, so work is being done to encourage its use. In addition, a stand alone Microsoft Access database is in its final stage of development for use by schools and other agencies interested in tracking BMI and health behaviors of a group of children. In future year, the use of this database will be required by agencies awarded community grants to decrease overweight in children, thus improving the NC-NPASS.

Trend data in the NC-NPASS system shows that for almost every age group, 2 to 4 years, 5 to 11 years, and 12 to 18 years, there has been a steady increase between 1995 and 2004 in the percentage of children who were overweight (BMI-for-age percentile >=95th percentile) or at risk for overweight (BMI-for-age percentile >=85th percentile and <95th percentile). Overweight percentages in the 12 to 18 year age group had leveled off somewhat at about 26% in the past four years but increased to 27.2% in 2004. The 5 to 11 year age group was not much lower in 2004 at 23.8%, and in the 2 to 4 year age group, 14.8% of children were overweight.

# IV. PRIORITIES, PERFORMANCE AND PROGRAM ACTIVITIES

## A. BACKGROUND AND OVERVIEW

Data collection and analysis for the majority of the National and State Performance measures are done collaboratively by staff within the WCHS and the State Center for Health Statistics. Specific information regarding most of these measures, including data sources and trends, can be found in the narrative portions for each measure and the detail sheet. The CSHCN Survey data, used in Performance Measures #2-#6, are made available through MCHB. As there is only one year of data for these measures, no statements regarding trends can be made. For the majority of the CSHCN measures, state rates were better than the national result. Due to a small sample size, a state rate is not available for Performance Measure #6 regarding youth with special health care needs and their transition to adulthood. Only for Performance Measure #4 regarding CSHCN whose families had adequate private/public insurance does NC fall just a bit below the national rate.

## B. STATE PRIORITIES

Based on further review of the NC Comprehensive Child Health Plan (our five-year needs assessment), the list of priority needs was slightly modified during FY2001. The following list is the revised list of priority needs which was used from FY01 to FY05.

1. Strengthening public health infrastructure at state and local level
2. Reducing disparities in health outcomes (racial/ethnic, geographical, socioeconomic, and for persons with disabilities)
3. Assuring access to high quality care for all segments of the MCH population
4. Increasing access to high quality health and related services in school settings by increasing the nurse-to-student ratio in NC public schools to an average of 1:750 or less
5. Assuring that the school health curriculum used in NC public schools comprehensively addresses a range of health and related issues relevant to school age children
6. Improving nutrition and fitness among children and adolescents
7. Improving pregnancy outcomes for all women
8. Reducing unintended pregnancies
9. Improving childhood immunization coverage through full implementation of a statewide computerized tracking system
10. Effective organization and delivery of family support (psycho-social, care coordination, home visiting) services for children and families

The changes to the list include dropping two previous priority needs -- 1)reducing occurrence and severity of injuries (particularly unintentional injuries) among children and adolescents and 2) enhancing monitoring, consultation and technical assistance to regulated child care centers to assure conditions that protect and promote health status of children -- and adding two new priority needs -- 1) Reducing disparities in health outcomes (racial/ethnic, geographical, socioeconomic, and for persons with disabilities) and 2)assuring that the school health curriculum used in NC public schools comprehensively addresses a range of health and related issues relevant to school age children. In addition, wording of some of the other priority needs has been amended to make them clearer.

During FY03, the SMT defined a consensus set of core WCH Indicators to be used to communicate the value of the work done by the WCHS with policymakers, stakeholders, and the general public. The purpose of defining the set of indicators was to be able to help the WCHS better define its mission and promote a common vision among staff. In addition, as these indicators are shared with stakeholders and policymakers, they provide information about how the work of the WCHS contributes to the welfare of the state. The process of defining the indicators also helped the SMT gain clarity about where evidence-based interventions exist and identify areas offering opportunities for improvement. Also, the choice of indicators helps Section staff understand core job responsibilities and evaluate performance as the indicators can be used in individual work plans. Another important outcome of the selection of indicators is that they allow for a more data-driven environment throughout the WCHS.

The first step at establishing core WCH indicators occurred during a SMT retreat of just branch heads and section level managers. After further refinement by SMT as successive meetings, these initial measures were then shared with the expanded SMT, which includes unit supervisors and other staff, for further feedback. The final set of WCHS Core Indicators are as follows:
1. Reduction of Infant Mortality
2. Improved Health of Women of Childbearing Age
3. Prevention of Child Deaths
4. Elimination of Vaccine-Preventable Diseases
5. Increased Access to Care for Women, Children, and Families
6. Prevention of Birth Defects
7. Improved Health of Children with Special Needs
8. Improved Healthy Behaviors in Women and Children and Among Families
9. Healthy Schools and Students who are Ready to Learn
10. All Newborns Screened for Genetic and Hearing Disorders
11. Provision of timely and comprehensive early intervention services for children with special developmental needs and their families.

At the same time that the Section was developing these indicators, the NC DHHS decided to implement performance based contracting using logic models as a component of performance based management. Thus, during FY04, the SMT members were responsible for leading work groups to create logic models for each of the eleven core indicators. Both regional and central office staff contributed to the models which are almost in the final draft stage. Logic models are by design a work in progress that can be revised as necessary to more clearly and correctly depict causal relationships and integrate program activities.

Thus, when it came time to determine the state MCH priority needs as part of the needs assessment process, the SMT quickly realized that while the results of the needs assessment information could help fine-tune the logic models, particularly the intermediate and end outcomes, these results only strengthened the argument that the WCHS Core Indicators reflected the priority needs of the Section. As each state is permitted to report only 7 to 10 priority needs, the NAT was tasked with consolidating the original 11 indicators into 10 priority needs. The NAT brought back several suggestions to the SMT who decided upon the following 10 priority needs to be used in the MCH Block Grant for the next five years. The attached table (Table I) indicates how these priority needs relate to the four service levels of the MCH pyramid and how they cover the three major MCH population groups. As noted, almost every priority need covers all realms of the pyramid and many of them cross over the three population groups.

## C. NATIONAL PERFORMANCE MEASURES

Performance Measure 01: *The percent of newborns who are screened and confirmed with condition(s) mandated by their State-sponsored newborn screening programs (e.g. phenylketonuria and hemoglobinopathies) who receive appropriate follow up as defined by their State.*

Tracking Performance Measures
*[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]*

| Annual Objective and Performance Data | 2000 | 2001 | 2002 | 2003 | 2004 |
|---|---|---|---|---|---|
| Annual Performance Objective | | | | 100 | 100 |
| Annual Indicator | 100 | 100 | 100 | 100 | 100.0 |
| Numerator | | | | | 234 |
| | | | | | |

| | | | | | |
|---|---|---|---|---|---|
| Denominator | | | | | 234 |
| Is the Data Provisional or Final? | | | | Final | Final |
| | **2005** | **2006** | **2007** | **2008** | **2009** |
| Annual Performance Objective | 100 | 100 | 100 | 100 | 100 |

**Notes - 2002**

Appropriate follow-up as defined by NC is provided to all newborns who are screened and confirmed with conditions mandated through the NC Metabolic Screening Program.

**Notes - 2003**

Appropriate follow-up as defined by NC is provided to all newborns who are screened and confirmed with conditions mandated through the NC Metabolic Screening Program.

**Notes - 2004**

Appropriate follow-up as defined by NC is provided to all newborns who are screened and confirmed with conditions mandated through the NC Metabolic Screening Program. These data are for CY03 and include testing for the following: Phenylketonuria, Congenital Hypothyroidism, Galactosemia, Sickle Cell Disease, MMA, Congenital Adrenal Hyperplasia (CAH), Medium Chain AcylCo-A Dehydrogenase (MCAD), 3-MCC, LCHADD, and other tests which accout for 6 cases.

## a. Last Year's Accomplishments

Evaluation of cut-off levels for abnormal and borderline primary hypothyroidism screens was completed and new cut-off levels have been implemented, resulting in a significant reduction in false positive newborn screen results. In addition, screening for Biotinidase Deficiency has recently been added to the NC newborn screen. Information about newborn screening is available on the State Laboratory for Public Health website (http://slph.state.nc.us/)

A coordinator for follow-up activities for newborn metabolic screening was hired in September 2003. This coordinator uses data provided by the State Laboratory for Public Health to track infants who have abnormal results on screening for Congenital Hypothyroidism (CH), Congenital Adrenal Hyperplasia (CAH), Galactosemia, and Biotinidase Deficiency. The infant's health care provider is called and the report of an abnormal screen is made, along with recommendations for further screening, testing, and care (e.g., through connections to an endocrinologist or metabolic specialist). Data describing these activities have been compiled semi-annually into a summary report that indicates the number of infants followed as well as the number of infants with confirmed conditions and receiving treatment. A protocol manual for follow-up coordination for abnormal CAH, CH, Galactosemia, and Biotinidase Deficiency screens has been drafted and reviewed by the Division of Public Health attorney. The Newborn Screening Advisory Committee will be the next stage of review.

In collaboration with the regional genetic counselors, the follow-up coordinator has also created a PowerPoint presentation detailing newborn metabolic screening in NC for the purpose of public awareness and education regarding newborn metabolic screening.

Two regional genetic counselors have also been trained to provide coverage for the activities of the follow-up coordinator in her absence.

The State Laboratory of Public Health also changed the length of time that the blood spot specimens are stored. Instead of storing the specimens for 2 years, the blood spots are now stored indefinitely.

**Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet**

| Activities | Pyramid Level of Service | | | |
|---|---|---|---|---|
| | DHC | ES | PBS | IB |
| 1. Initial newborn screening test performed on all blood spot samples received. | | | X | |
| 2. Follow-up of borderline results with a letter to physician. | | | X | |
| 3. Follow-up of abnormal results with a phone call to physician. | | | X | |
| 4. Testing of repeat blood spots received following a borderline or abnormal screen. | | | X | |
| 5. Continued interaction of state laboratory staff and medical center staff as relates to questionable results. | | | | X |
| 6. Contracts providing statewide coverage for consultation related to metabolic conditions. | | | | X |
| 7. Work towards development of data linkage of newborn screening records and birth certificates. | | | | X |
| 8. Purchase of special formula for individuals with certain metabolic disorders through Nutrition Services. | | X | | |
| 9. Monitoring of phe/tyr ratios in blood spots received from individuals with PKU. | | | X | |
| 10. Newborn screening advisory committee quarterly meetings. | | | | X |

## b. Current Activities

The effect of the new CH cut-off established in November 2004 is being evaluated. During September 2004 through January 2005, the number of abnormal CH newborn screens decreased from 82 in September and 85 in October to 33 in November and 15 in December and also in January, thus dramatically decreasing the CH false-positive rate in NC.

The cut-off levels and the primary analytes/analyte combinations used in tandem mass spectrometry (MS/MS) are being evaluated to fine-tune the determination of normal, borderline, and abnormal classifications of MS/MS newborn screen results. The development of a software program to automate classification schemes is being discussed.

The Newborn Metabolic Screening Follow-Up Coordinator is drafting a PowerPoint presentation about Biotinidase Deficiency for use in educating the medical community about this disorder which should be completed and available for distribution among the regional genetic counselors by the end of the fiscal year. The Coordinator is also working to update the newborn screening parent brochure "A Test to Save Your Baby's Life." The brochure is currently in draft stage and has been reviewed by the following groups: NC State Lab, NC Sickle Cell Program, metabolic geneticists at UNC-Chapel Hill, pediatric endocrinologists at Wake Forest University Baptist Medical Center, and WCHS Family Advisory Council.

A consultant for follow-up activities for newborn hemoglobinopathy screening was hired in September 2004. This consultant relies on data provided by the State Lab to ensure that all babies diagnosed with sickle cell disease are placed on penicillin by three months of age.

Approximately 3000 clients (infants, children and adults) are currently enrolled in the NC Sickle Cell Syndrome (NCSCS) Program. The computer database that is used to track the services provided to these clients, SCELL, will be updated this year. Program services include genetic counseling/education, medical care, and child service coordination services. The system also

records the client's demographic, contact, and financial information. With the wealth of information stored in SCELL, the consultant is able to generate statistics on various topics related to sickle cell disease and disseminate the data to requesting public agencies or individuals. The information captured in SCELL also allows program staff to examine ways of enhancing current case management practices.

The NCSCS Program held its first strategic planning session in February 2005 to begin looking at ways of enhancing the quality of service to clients and families. Staff participated in an informal but structured review of program activities, components, and services that helped initiate the identification of standards of care, along with gaps and barriers that influenced the continuity in service delivery. A new web site has been designed and completed by the Program to improve public awareness and education.

The State Lab successfully passed CLIA inspection.

### c. Plan for the Coming Year

Evaluation of the effect of the new CH cut-off will continue through the upcoming year on a semi-annual schedule. Also, age and birth weight parameters will be evaluated during the upcoming year for further revision of the CH cut-offs.

Collaboration between the coordinator for newborn metabolic screening and the regional genetic counselors will continue to be emphasized as educational presentations and materials are developed regarding newborn screening and genetic conditions. Coverage for follow-up coordination activities when the coordinator is away will also continue through periodic re-training of regional genetic counselors. The Unit Manager will continue to help focus efforts on outcomes for the program, including evaluation of data, protocol, and coverage implementation.

Efforts to finalize updates to the newborn screening parent brochure will continue. Printing and distribution of the parent brochure to the medical community involved with newborn screening is expected to occur this year. A similar brochure for physicians and other professionals may be written during the upcoming year.

The NCSCS Program has been able to build capacity and better serve clients through the development of a logic model. This model outlines short and long-term goals set by the program. Each of these goals has a completion date. To illustrate, the Program aims to decrease the number of hospitalizations related to sickle cell disease by the year 2008. In the coming year, the program will work towards these goals and use the logic model as a tool to better measure its success and draw attention to any areas needing improvement.

Performance Measure 02: *The percent of children with special health care needs age 0 to 18 years whose families partner in decision making at all levels and are satisfied with the services they receive. (CSHCN survey)*

Tracking Performance Measures
*[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]*

| Annual Objective and Performance Data | 2000 | 2001 | 2002 | 2003 | 2004 |
|---|---|---|---|---|---|
| Annual Performance | | | | 75 | 75 |

| | | | | | |
|---|---|---|---|---|---|
| Objective | | | | | |
| Annual Indicator | | | 65.3 | 65.3 | 65.3 |
| Numerator | | | | | |
| Denominator | | | | | |
| Is the Data Provisional or Final? | | | | Final | Final |
| | **2005** | **2006** | **2007** | **2008** | **2009** |
| Annual Performance Objective | 75 | 75 | 75 | 75 | 75 |

**Notes - 2002**

The 2002 indicator is based on the State estimate from SLAITS.

**Notes - 2003**

The data reported in 2002 have pre-populated the data for 2003 for this performance measure.

**Notes - 2004**

The data reported in 2004 are pre-populated with the data from 2003 for this performance measure.

## a. Last Year's Accomplishments

During FY04, Family Advisory Council (FAC) members participated in C&Y Branch, EI Branch, and interagency committees. Members contributed to the redesign plan for EI, defining responsibilities and staffing needs of the Regional Interagency Coordinating Councils, and were representatives on local, regional and state councils. Members reviewed EI and WCHS policies. They educated others by serving on the Governor's Commission for CSHCN, as members of a Medicaid Review Board, and with local and regional training initiatives. They were members of the Community Advisory Council for the tertiary medical centers, served as support parents for families in NICUs, and advocated for pertinent legislative issues. Members participated in the AMCHP conference and worked with the Exceptional Children's Assistance Center and WCHS to strengthen Family Voices NC. One member was involved in the implementation of a medical childcare demonstration project. Members received stipends for FAC meetings and activities. The diversity of the FAC grew; members represented different races, cultures, geographic areas, and child health needs.

The Family Liaison Specialist staffed the activities of the FAC and worked to energize FAC members to become more informed and committed to the state Title V program by increasing understanding of their role in improving system outcomes. She assisted families on individual issues and advised staff on the development and promotion of family perspectives, family centered care, care coordination, transition planning, medical home and community resources. The FLS led the acquisition of a Champions for Progress grant.

Family Voices was co-administered by a staff member of the ECAC and a FAC leader. Collaboration among community and state Title V programs in support of ECAC's application for the Family to Family Health Information Center Grant was successful. ECAC began implementation of the grant with FAC members and the FLS involved in the design and implementation plan.

Other mechanisms within WCHS provided opportunities for family involvement. Parents of CYSHCN represented the family perspective on the NC Commission on CSHCN. Two parents sat on the Early Detection and Hearing Screening Advisory Board. Fathers of CYSHCN were involved with the statewide Fatherhood Initiatives.

The toll-free Help Line for CYSHCN continued receiving input from family members and was a source of information on an array of topics. Data summarizing calls was compiled and presented regularly to the Commission on CSHCN. Persons with disabilities and family members continued to be an integral part of the ongoing work of the NC Office of Disability and Health (NCODH), housed within the C&Y Branch. Adults with disabilities were in key NCODH staff positions and engaged as consultants, trainers and advisors. The Office's initiatives to improve access to health promotion and disease prevention services positively influenced systems of care for CYSHCN.

**Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet**

| Activities | Pyramid Level of Service | | | |
|---|---|---|---|---|
| | DHC | ES | PBS | IB |
| 1. Involvement of families of CSHCN in WCHS through FAC and the Family Liaison Specialist. | | | | X |
| 2. Children with Special Health Care Needs Helpline (Toll-free) will continue to provide information and support for families of CSHCN. | | X | | |
| 3. Parent members will continue to work with the NC Commission on Children with Special Needs. | | | | X |
| 4. At least two representatives from the Family Advisory Council will attend AMCHP conferences. | | | | X |
| 5. | | | | |
| 6. | | | | |
| 7. | | | | |
| 8. | | | | |
| 9. | | | | |
| 10. | | | | |

b. Current Activities

In FY05, family involvement across programs and initiatives within the C&Y Branch has increased. The primary focus of the FLS is the staffing of the FAC. Another is collaborating with key C&Y Branch staff engaged in efforts to eliminate racial, disability and ethnic disparities, including the development of a collaborative plan for infusing cultural competence across C&Y Branch activities. Additionally, ongoing efforts to address the elimination of health disparities throughout WCHS and training for cultural competency with the UNC-CH MCH Consortium continue.

The FAC has continued to develop its roles of advising, planning, and advocacy. Particular activities have included working with stakeholders to strengthen Family Voices, supporting the restructuring EI design plan, and offering insights into the development of the Family to Family Health Information Center. One activity, assisting the C&Y Branch staff in the development of the MCHB Needs Assessment, has received invaluable FAC support. FAC family leaders coordinated the parent and professional focus group activities across the state, and FAC members piloted the questions for the final statewide focus group effort. A major FAC objective continues to be the development of strategies for expanding family participation at the local and regional levels relative to CSHCN. The Champions for Progress Grant supports statewide community educational activities and the development of 2 Family Led Community Action Team pilot sites. Arizona Title V CSHCN program staff and family leaders provide technical assistance with the pilot site development activities. FAC members are developing a FAC

brochure and were instrumental in designing the Champions-supported educational curriculum for data dissemination. Leadership advancement continues to be an FAC activity. Members are developing governance structures for the operations of the FAC, including term limits. As the present co-facilitators prepare to rotate out of leadership positions, other members are preparing to assume these roles. Increasing diversity of the FAC remains a strong focus.

The FLS organizes planning retreats for the FAC and continues with community outreach site visits statewide. On the national level, she works with the Healthy and Ready to Work project, the National Center for Cultural Diversity, Family Voices, and the Champions for Progress project.

The NCODH continues to provide technical assistance toward ensuring a life span oriented approach to both C&Y Branch and DPH health promotion and service delivery initiatives. Adults with disabilities continue to provide guidance as to how services can be improved for children and adolescents with disabilities and chronic health conditions. The NCODH has launched several community-based demonstration efforts, implemented by teams of individuals with disabilities, to improve access to fitness environments, medical care clinics, cancer screening, and worksite health promotion.

## c. Plan for the Coming Year

During FY06, leadership for proceeding with NPM#2 and components of Outcome Measure #1 in the Specialized Services Unit (SSU) Logic Model will be provided by the FLS. In addition to the FAC, she will assemble teams of internal and external advisors to assess what has been accomplished to date in NC and the extent to which additional needs assessments should be undertaken. Funding has been budgeted for grassroots involvement and for the second annual FAC Planning Retreat. Family involvement objectives are delineated under Outcome Measure #1 of the SSU Logic Model. Specific outputs for the coming year include the following:
-Utilize input from the FAC on an ongoing basis in developing policy within the C&Y Branch;
-FAC members and other family members of C/YSHCN routinely participate in planning, implementation and evaluation of Branch and WCHS programs;
-Conduct an assessment of how state C/YSHCN programs are engaging parents as partners and report findings to the FAC by the end of FY06. Explore linkages to the EI Branch efforts on family involvement data as part of this assessment;
-Develop, expand, and review strategies and mechanisms that assure that FAC members function as liaisons between parents in local communities and the C&Y Branch;
-Develop and distribute a newsletter for families of C/YSHCN twice a year;
-Ensure attendance of parent representatives at the AMCHP Annual Meeting;
-Strengthen linkages to the Family Support Network, Family Voices, and ECAC as well as other family support and advocacy groups on an ongoing basis;
-Identify the information given and strategies used in each of the MCH sponsored Information and Referral lines to provide support to families of C/YSHCN in order to strengthen linkages and to promote consistently available information across the Birth-21 age range; and
-Convene a C&Y Branch cultural competence work group to be responsible for: 1) Determining the racially/ethnically/culturally and linguistically diverse groups served by the C/YSHCN Program; 2) Identifying and beginning collaboration with consumers, community-based organizations and informal networks of support to identify benchmarks/standards, and developing new approaches for delivering family-centered care in a culturally and linguistically appropriate manner; 3) Conducting an organizational cultural competence self-assessment in conjunction with other Units of the C&Y Branch; 4) Conducting an assessment of current C&Y Branch direct service practices regarding cultural competence, and identifying ways to share effective strategies; and 5)Developing a mission statement for the C/YSHCN Program that commits to cultural competence, being family centered, access, and inclusion as integral components of all of its activities.

Finally, the SSU will develop an integrated work plan for family involvement with other key SSU initiatives including, but not limited to, Medical Home and Transition by the end of FY06.

Performance Measure 03: *The percent of children with special health care needs age 0 to 18 who receive coordinated, ongoing, comprehensive care within a medical home. (CSHCN Survey)*

Tracking Performance Measures
*[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]*

| Annual Objective and Performance Data | 2000 | 2001 | 2002 | 2003 | 2004 |
|---|---|---|---|---|---|
| Annual Performance Objective | | | | 75 | 75 |
| Annual Indicator | | | 55.6 | 55.6 | 55.6 |
| Numerator | | | | | |
| Denominator | | | | | |
| Is the Data Provisional or Final? | | | | Final | Final |
| | **2005** | **2006** | **2007** | **2008** | **2009** |
| Annual Performance Objective | 75 | 75 | 75 | 75 | 75 |

**Notes - 2002**

The 2002 indicator is based on the State estimates from SLAITS.

**Notes - 2003**

The data reported in 2002 have pre-populated the data for 2003 for this performance measure.

**Notes - 2004**

The data reported in 2004 are pre-populated with the data from 2003 for this performance measure.

## a. Last Year's Accomplishments

The NC Medical Home Initiative for CYSHCN was a priority area of focus for planning, collaboration and resource development during FY04. Conceptually, the NC Medical Home Initiative was designed to integrate with the existing Title V and primary care infrastructure and to use processes and approaches with demonstrated efficacy in building systems of care for children and their families in this state. This initiative was segmented into eight dimensions of complementary planning, including:
-Title V Staff support
-Advisory Board to the Medical Home Initiative for CYSHCN
-Public Education Campaign
-Parent Training and Education
-Provider Training and Education
-Demonstration Project through Chapel Hill Pediatrics
-Demonstration Project through the NC Office of Research, Demonstrations, and Rural Health Development (ORDRHD)
-Linkage with the Medical Centers that house pediatric residency programs.

The SSU redefined a vacant position to serve as coordinator for the Medical Home Initiative for CYSHCN in NC; however, that position remained vacant throughout the year.

The SSU Manager worked intensively with the National Initiative for Children's Healthcare Quality (NICHQ) and the NC Pediatric Society to develop and provide training for providers regarding Medical Homes for CYSHCN. In addition, she engaged in negotiations with key collaborators. Major accomplishments included the following:
-Continued support for the work done at Chapel Hill Pediatrics. The practice team there participated in a 15 month Learning Collaborative on implementing the concepts of Medical Home for CSHCN in a primary care pediatric practice.
-Collaborated with the ORDRHD on how Community Care of NC networks could develop capacity to support their network of community-based practices to serve as Medical Homes for C/YSHCN. Guilford Child Health agreed to be the first Community Care network to accept this challenge. The engagement one network as an initial partner and then expanding to other sites is the process historically used by the ORDRHD in introducing innovation in the Community Care networks.
-Negotiated a contractual scope of work with the NC Healthy Start Foundation to develop additional Medical Home Campaign materials for use in the Health Choice/Health Check project sites and in the state "The Right Call Every Time" Campaign. This initiative focused on the integration of C/YSHCN into the existing campaign and it provided for the development of other specific educational resources for parents of C/YSHCN.
-Developed a contractual scope of work with the Family Support Network-NC (FSN-NC) to expand capacity to train parents on different aspects of promoting the Medical Home Initiative for CSHCN.

**Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet**

| Activities | Pyramid Level of Service | | | |
|---|---|---|---|---|
| | DHC | ES | PBS | IB |
| 1. Educate the families of children enrolled in HC and NCHC on the importance of the medical home. | | | | X |
| 2. Support systems of care that assure children are screened early and often for special health care needs. | | | | X |
| 3. Maintain toll free CSHCN Help Line for information about appropriate programs, services and providers. | | X | | |
| 4. Conduct presentations on the Medical Home Initiative at statewide professional meetings. | | | | X |
| 5. Support systems of care that assure CSHCN are linked with a medical home for follow-up. | | | | X |
| 6. | | | | |
| 7. | | | | |
| 8. | | | | |
| 9. | | | | |
| 10. | | | | |

b. Current Activities

Plans are underway for a State Learning Collaborative on medical homes. NC Center for Child Health Improvement (NCCCHI) will be organizing an 18-month Learning Collaborative on improving the medical home in the primary care practice beginning in September 2005. After each learning session, the practice will implement a Plan-Do-Study-Act (PDSA) model of

practice change. Currently, we are in the process of planning curriculum, recruiting practices, and doing data collection. Members of the NC Medical Home Initiative for C/YSHCN workgroup will serve as the Community Advisory Group and will be invited to attend the Collaborative.

DPH and the NCHSF are working on a project that promotes the concept of the medical home through Health Check and Health Choice to families who were using the emergency department (ED). A significant amount of research to determine available resources was done, and while there are a number of good materials available for professionals, there are few for parents/families. The workgroup identified the need to explain what a medical home is to families, explain how to choose a quality medical home to a family, and prepare families for their role as partners, so they have proposed "Bookmarks" on Choosing a Quality Medical Home and Key Resources. Information about transition will be included on the flip side of the Key Resources Bookmark since few of the resources are available in Spanish.

The workgroup has begun discussions on how a "Care Organizer" would relate to a medical Care Plan that the physician/family would develop. Title V has been asked to assist in the development of Care Plans for CYSHCN.

Work continues on Medical Home improvement and integration as a part of the Early Childhood Comprehensive Systems (ECCS) planning grant. Members of this workgroup presented information as "experts" to the Think Tank providing oversight to the ECCS project.

FSN-NC continues working with the FSN programs in Guilford, Wilmington, and Piedmont region along with Chapel Hill Pediatrics (CHP) to disperse information to families regarding the medical home project. In conjunction with the medical home workgroup, CHP is currently working on the following activities:
- A Family Forum entitled "Developing a Strong Partnership among Family, School and Pediatrician for Educational Support of Children with Special Health Care Needs" will be held in response to parents' questions about developing partnerships.
- A Parent Listening Session for families who use the CHP is planned. FSN-NC and Title V will facilitate this session to allow families to share what makes a successful medical home.
- CHP is making a transition from Doc Site to Medical Manager (database system).
- A survey of satisfaction with pre-visit contacts was conducted.
- ED and after hours usage data has been analyzed.

The Community Care Networks are continuing to work on quality improvement projects, one of which is improvement of the medical home concept.

## c. Plan for the Coming Year

Implementation of the 18-month long State Learning Collaborative on MH will begin in September 2005. Emphasis will be on improving the medical home in the primary care practice. Participating practices will be assisted with the PDSA cycles by NCCCHI, Title V, CHP and ORDRHD staffs.

The ED and after hours care data gather by CHP has been finalized, and a 50% reduction in use of the ED was found. The next step is to attach dollar figures so the information can be better utilized.

The workgroup will continue to plan activities to market the medical home concept to families as materials development that was started in FY005 continues. (See NPMs13 and 14 for further information).

The workgroup will continue to gather information and consider whether a "Care Organizer" that would relate to a medical Care Plan that the physician/family would develop would be

utilized by families. Further exploration of the development of Care Plans for CYSHCN will occur as part of the State Collaborative for CYSHCN. (See NPM 2 for related information.)

Work continues on medical home improvement and integration as a part of the ECCS planning grant. Members of this workgroup will serve as advisory to the medical home work that will occur during the implementation phase of the ECCS project. (See NPM 5 for related information).

DPH has begun to look at the possibility of revising the Kindergarten Health Assessment (KHA) form. Plans are to conduct a systematic assessment of desired used of the KHA information along with the development of a comprehensive plan for achieving those objectives and the development of a plan to pilot test automated entry of KHA information. This is a related project for the medical home workgroup.

Performance Measure 04: *The percent of children with special health care needs age 0 to 18 whose families have adequate private and/or public insurance to pay for the services they need. (CSHCN Survey)*

Tracking Performance Measures
*[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]*

| Annual Objective and Performance Data | 2000 | 2001 | 2002 | 2003 | 2004 |
|---|---|---|---|---|---|
| Annual Performance Objective | | | | 80 | 80 |
| Annual Indicator | | | 57.3 | 57.3 | 57.3 |
| Numerator | | | | | |
| Denominator | | | | | |
| Is the Data Provisional or Final? | | | | Final | Final |
| | **2005** | **2006** | **2007** | **2008** | **2009** |
| Annual Performance Objective | 80 | 80 | 80 | 80 | 80 |

**Notes - 2002**

The 2002 indicator is based on the State estimate from SLAITS.

**Notes - 2003**

The data reported in 2002 have pre-populated the data for 2003 for this performance measure.

**Notes - 2004**

The data reported in 2004 are pre-populated with the data from 2003 for this performance measure.

a. Last Year's Accomplishments

During FY04, the WCHS continued to use the results of the Sheps Cross-Insurance study to determine how the Health Check and Health Choice (HC/NCHC) Programs could be improved to better meet the needs of C/YSHCN. Differences between Medicaid, Carolina Access, and

Health Choice were assessed in the context of the NC Medical Home Initiative. Carolina Access was established for the primary purpose of creating linkages for most Medicaid children to a medical home. Children are linked at the time of enrollment or re-enrollment for Medicaid benefits. While this did not assure the level of coordination associated with the federal definition of a medical home, it did serve as an important structural element in building a system of care for most Medicaid eligible children. Prior to the program, most children had to seek primary care from the emergency department. In contrast, Health Choice is a fee-for-service open indemnity program. Enrollees are free to choose any provider willing to accept Health Choice. No legislative provisions were made for establishing a medical home, which has served as a challenge in assuring that enrollees are linked to a primary care provider who can serve as a medical home. The current Medical Home Campaign (see NPM #13) is intended to strengthen early linkages to primary care providers.

NC has made several important attempts to identify C/YSHCN in the Medicaid Program. In 2000, the Living with Illness screening questions were included on the HC/NCHC Application. The hope was that parents would complete this at the time of application and allow for a flagging mechanism to be entered along with enrollment data into the Eligibility Information System. Unfortunately, the experience to date has been that this section of the application has not been consistently completed. In lieu of data, DMA has been forced to rely on the federal operational definition of C/YSHCN, or 13% of the Medicaid population of children who meet the criteria which includes the following categories: blind/deaf, out of home placement, SSI eligible, on Health Choice, and having mental retardation. DMA conducted a retrospective chart audit of Medicaid child recipients to assess the prevalence of children meeting the above definition.

To improve the quality of the mental health benefits within HC/NCHC, the WCHS led an effort to redefine the standards for who can provide Level III Group Home care. Concerns had been raised about the high cost of Level III Group Home care and about the quality of services these homes delivered. The Behavioral Health Workgroup was convened for this purpose.

The Special Needs Toll-free Helpline continued to be the focal point for information on state and local programs and resources for CSHCN. From October 1998 (kickoff for our state's SCHIP) through June 2004, the Helpline handled 11,966 calls. For the majority of callers, health insurance issues were central to the conversation.

(See NPMs 13 and 14 for further information.)

**Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet**

| Activities | Pyramid Level of Service | | | |
|---|---|---|---|---|
| | DHC | ES | PBS | IB |
| 1. Maintain HC/NCHC Outreach Campaign through the NC Healthy Start Foundation. | | | X | |
| 2. Maintain NC Family Health Resource Line as a bilingual informational telephone hotline. | | | X | |
| 3. Develop HC/NCHC Outreach web site. | | | X | |
| 4. Develop HC/NCHC educational campaign regarding medical home/ER use/preventive care. | | | X | |
| 5. Support grant-funded initiatives: NC Covering Kids and Families and Wake Rex Foundation Project. | | | | X |
| 6. Simplification of enrollment/re-enrollment forms and development of family-friendly notices. | | X | | |
| | | | | |

| | | | | |
|---|---|---|---|---|
| 7. Development of comparable data sets for HC and NCHC. | | | | X |
| 8. Targeted outreach to special populations (including minority and CSHCN). | | | X | |
| 9. | | | | |
| 10. | | | | |

## b. Current Activities

During FY05, leadership for proceeding with NPM#4 and components of Outcome Measure #1 in the SSU Logic Model were provided by the C&Y Branch Head, the HC/NCHC Outreach Coordinator and the SSU Manager. The C&Y Branch refined its organizational changes this year and in so doing, decided to place both the Health Choice Special Needs and the C/YSHCN Helpline positions in the SSU. This change was designed to enable the Branch and the Unit to more effectively develop strategic plans for assisting families with insurance issues.

The C&Y Branch Head, the HC/NCHC Outreach Coordinator and the SSU Manager collaborated with internal and external partners, including the Commission for CSHCN, to assess what has been accomplished to date in NC and the extent to which additional needs assessments should be undertaken.
Activities included:
-Use of information found in the January 2003 study from the Sheps Center and utilization data from Medicaid and the SEHP to evaluate the number of C/YSHCN who had inadequate or no insurance coverage;
-Assured integration of C/YSHCN coverage into insurance studies undertaken by the SCHS;
-Collaborated with the NC Interagency Coordinating Council (NC-ICC) on the promotion of insurance legislation for children in early intervention;
-Collaborated with consumers, community-based organizations and other stakeholders, including the Commission on CSHCN and the FAC, to identify and advocate for third party coverage of services required for C/YSHCN, as well as provide support for reasonable fees and reimbursement policies for services already covered;
-Continued clinical and programmatic review of requests for CSHS/POMC Program, metabolic requests, the Health Choice Special Needs Program, and the Assistive Technology funds;
-Collaborated with the Access to Care Unit and the Commission for CSHCN to assess the needs of Youth with Special Health Care Needs age 18 and older for ongoing health care coverage; and
-Promoted increased awareness of the importance of health insurance for young adults with special health care needs above age 21 in being able to pursue employment, secondary education and independent living on an ongoing basis; and
-The Commission on CSHCN Behavioral Health Workshop drafted recommendations for improving Level III Group Home services for children enrolled with Medicaid and Health Choice. Those recommendations were submitted to the DHHS Secretary for further consideration.

(See NPMs 13 and 14 for further information.)

## c. Plan for the Coming Year

The Health Choice Special Needs position continues to be vacant; however, interviews have been completed and it is anticipated that it will be filled in the near future. Filling this key position will enable the C&Y Branch and the Unit to more effectively develop strategic plans for assisting families with insurance issues.

Activities planned for FY06 include:
- The Commission on CSHCN Behavioral Health Workshop will continue to provide input to the Department related to improving Level III Group Home services for children enrolled in

Medicaid and Health Choice.
-The C&Y Branch will continue to strengthen capacity of the NC Family Health Resource Line (Title V Hotline) to help families understand the importance of maintaining health care coverage and their rights when transitioning C/YSHCN from one insurance plan to another. Insurance fact sheets/other information from the NC Department of Insurance will be incorporated into the resource database which is used by resource line staff.
-The Medical Home Initiative will continue to be promoted among Health Choice enrollees to foster the early and ongoing link to a level of primary care that will encourage families to make sure children stay insured. (See NPMs 13 and 14 for further information).
-A new edition of the NC Health Choice Information for C/YSHCN Booklet will be published to help the families of Health Choice enrollees better understand and fully access the wrap-around services available to their children.
-The name of the "Special Needs Helpline" will be changed to "Children and Youth with Special Health Care Needs Helpline" and a public awareness campaign will be developed. This will enable families to obtain information on accessing health care coverage as well as guidance on fully accessing the services already available to children enrolled in Medicaid, Health Choice and private insurance plans. A new business card for the C/YSNCH Helpline will be developed, with plans for broad distribution.
-Through the Healthy Transitions to Adulthood Initiative, work to improve communication between and within key agencies that serve C/YSHCN (ages 13-21) will continue. (See NPM # 6 for further information).
- The first NC C/YSHCN newsletter will be developed. (See NPM 2 for further information).

Performance Measure 05: *Percent of children with special health care needs age 0 to 18 whose families report the community-based service systems are organized so they can use them easily. (CSHCN Survey)*

Tracking Performance Measures
*[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]*

| Annual Objective and Performance Data | 2000 | 2001 | 2002 | 2003 | 2004 |
|---|---|---|---|---|---|
| Annual Performance Objective | | | | 90 | 90 |
| Annual Indicator | | | 80.6 | 80.6 | 80.6 |
| Numerator | | | | | |
| Denominator | | | | | |
| Is the Data Provisional or Final? | | | | Final | Final |
| | **2005** | **2006** | **2007** | **2008** | **2009** |
| Annual Performance Objective | 90 | 90 | 90 | 90 | 90 |

**Notes - 2002**

The 2002 indicator is based on the State estimate from SLAITS.

**Notes - 2003**

The data reported in 2002 have pre-populated the data for 2003 for this performance measure.

**Notes - 2004**

The data reported in 2004 are pre-populated with the data from 2003 for this performance measure.

## a. Last Year's Accomplishments

During FY04, the EI Branch continued to move forward with plans to implement major changes in the EI system. The planned system revision led to major changes for Child Service Coordination (CSC) Providers at the local level, which led to an increased demand for technical assistance to CSC Providers. The CSC program worked closely with the EI Program to develop accurate information for CSC Providers regarding roles and responsibilities, which was shared with CSC Providers numerous times in different formats.

Revisions were made in the technical assistance provision for local CSC Providers to ensure consistency and accuracy. The CSC Program continued providing CSCP Updates with information that impacted service provision to local providers. Orientation for new CSC staff was revised and a standardized curriculum began being offered quarterly at 4 regional sites. The CSC Program collaborated with numerous agencies serving children ages 0-5 to ensure a comprehensive system of care.

The CSC program policies were reviewed in conjunction with DMA. The program continued to work with DMA to implement the revised definitions to Risk Indicators and Diagnosed Conditions, along with a revised Identification and Referral Form.

The Hospital Early Intervention (HEI) programs continued to provide EI services to families whose children were hospitalized over 30 days in the NICUs. The HEI Advisory Board met to ensure that these programs were working closely with community based services.

Further evaluation of Children's Special Health Services (CSHS) Clinics, the Assistive Technology Resource Centers (ATRC), and the Special Needs Helpline continued in the context of C&Y Branch re-organization and the development of the Logic Models. CSHS Specialty Clinics continued to decrease in number as access to private clinics with either Medicaid or Health Choice insurance increased. A high percentage of the Orthopedic Clinics in the LHDs continued to serve those without means of payment.

The ATRCs loaned 6,305 Assitive Technology (AT) devices to CYSHCN. CSHS continued to provide AT through 72% of its budget. The AT Fund provided 1,764 devices to 304 CSHCN who are 0 to 3 years old.

A new priority was established to work with the ATRCs and the Regional Physical Therapy staff on the development of a program to re-cycle AT Equipment. Another initiative that was begun was the revision of the CSHS Administrative rules. Finally, in order to assure more opportunity for family input, a Family Liaison Specialist was hired in February 2004. This has resulted in significant improvement in the integration of parents and family members in the development, implementation, and assessment of programs and policies and systems of care. (See NPM #2 for further information.)

The Special Needs Helpline services continued to serve families with information regarding programs serving CYSHCN, particularly CSHS and the access process.

**Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet**

| Activities | Pyramid Level of Service | | | |
|---|---|---|---|---|
| | | | | |

| | DHC | ES | PBS | IB |
|---|---|---|---|---|
| 1. Continue Community Transition Program. | | | X | |
| 2. Continue Child Service Coordination Program. | | X | | |
| 3. Continue provision of Early Intervention services and implementation of system design changes. | X | | | |
| 4. Continue CSHS Clinics. | X | | | |
| 5. Continue Children with Special Health Care Needs Helpline | | X | | |
| 6. Continue Child Care for children who are medically fragile. | X | | | |
| 7. Implement Hospital Early Intervention Projects. | X | | | |
| 8. | | | | |
| 9. | | | | |
| 10. | | | | |

b. Current Activities

During FY05, leadership for NPM#5 and Outcome Measure #1 in the SSU Logic Model has continued. Activities have included:
-Analysis of the National Survey for CYSHCN to determine characteristics associated with comprehensiveness and satisfaction with systems of care
-Participation in activities of the following groups: Commission CYSHCN, NC Pediatric Society, NC Partnership for Children, Family Resource Health Line, Family Support Network, ECAC, NC DD Council, State Collaborative for Children/Families, Early Childhood Comprehensive Systems Grant, and Behavioral Health Committee
-Work with the NC Interagency Corrdinating Council (NC-ICC) and committees to improve services for children age 0-5 with special needs and their families
-Participation in and provision of leadership, technical support, and resources to statewide family support/family involvement initiatives
-Development, expansion, and review/revision of strategies and mechanisms to assure FAC members function as liaisons between parents in local communities and C&Y Branch (See NPM #2 for further information.)
-Planning and implementation of the ECCS Planning Grant
-Completeion of the Shared Vision/Shared Outcome process identified through the ECCS planning grant to improve outcomes for all children
-Identification of strategies/mechanisms for enhancing prevention, intervention and treatment for CYSHCN through Healthy Childcare and Medical Childcare initiatives, School Health Initiative, well child and adolescent clinics, CSHS clinics, CSHS rules, and other CSHS Programs
-Identification of age-specific activities and strategies that the CTC Program, Special Infant Care Follow-Up Clinics, CDSAs, and CSC Program contribute
-CSC Program continues to be available in every county via LHDs or other providers to offer case management/care coordination for families of children at risk for or diagnosed with developmental delays
-Continued efforts to revise the CSC DMA Bulletin
- Provision of consultation, technical assistance and training to increase awareness among families, private therapists, and provider agencies regarding accessing available resources at state and community levels
-Partnership with private and public agencies/organizations to support cultural diversity training and other means of assuring that families receive family centered, accessible, inclusive and culturally sensitive services
-Standardization of CSHS Program Policies and Procedures and revision of CSHS Administrative Rules. New rules will eliminate the need for pediatricians to be rostered through the C&Y Branch
-Revision of ATRC database to accurately report services to CYSHCNs/families and provide

performance data needed for contracts
-Coordination of initiatives for CYSHCN by regional physical therapists in the areas of oral health/access to dental care, physical activity/nutrition, and improving the health of children in the foster care system.

## c. Plan for the Coming Year

Plans for the CSC Program are to:
-Develop standardized training and assessment tools that define CSC goals;
-Redesign and distribute outreach materials to ensure children are appropriately identified;
-Analyze service provision data to maximize use of funds;
-Fully implement TA database;
-Continue Regional Meetings, CSCP Update, and Quarterly Regional Orientation;
-Develop a self-instructional packet to orient staff;
-Finalize development of monitoring system integrated into Branch monitoring activities;
-Revise Risk Indicators/Diagnosed Conditions and the Identification and Referral Form with DMA;
-Develop expertise in social-emotional arena; and
-Collaborate with EI and other agencies to ensure comprehensive system of service delivery.

Plans for the CSHS Program are to:
-Complete revisions to the Program Policy and Procedure Manual and the Administrative Rules;
-Work with ATRC sites to expand the use of AT equipment;
-Define CSHS Program responsibilities/obligations to the NC Medicaid system;
-Continue statewide initiatives of outreach and assistance in preventative health to CYSHCN by partnering with those who are already initiating prevention; and
-Assist in the provision of clinics and services for CYSHCN through local and non-local contracts.

Plans for the SSU in general include working with:
- The court system to improve the developmental outcomes for children in that system (includes working with Foster Care, DSS, GAL, and Family Courts);
-The State Collaborative on systems of care for children with mental health issues (application for a Title V grant to improve mental health services for CYSHCN is currently being developed); and
-Tertiary centers to strengthen relationships with the Special Infant-Care follow-up clinics and develop ways to improve screening for children born in hospitals other than tertiary centers.

Transition for young children plans include:
-Working with programs serving young children moving between CSCP/EI and the public school system; and
-Having staff, including CSC Program Manager, Social Work Consultant, and FLS, work with various NC-ICC subcommitees to improve systems, outcomes, and cultural competence.

Continue ECCS activities to:
-Create a breakthrough in NC's ranking on key measures of child well-being by working collaboratively to create an integrated, comprehensive early childhood system that supports school readiness and uses evidence-based practices;
-Link the results of the shared outcomes/indicators project to all components of the ECCS;
-Address the challenges associated with developing a shared ECCS database;
-Infuse the ECCS with people who have core competencies in early childhood, practical approaches, and community relationships necessary to provide effective services to children and families;
-Build a philanthropic/government partnership; and

-Secure the commitment of families, stakeholders and decision makers about costs, benefits and consequences of building or neglecting a comprehensive, integrated ECCS.

Performance Measure 06: *The percentage of youth with special health care needs who received the services necessary to make transition to all aspects of adult life. (CSHCN Survey)*

Tracking Performance Measures
*[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]*

| Annual Objective and Performance Data | 2000 | 2001 | 2002 | 2003 | 2004 |
|---|---|---|---|---|---|
| Annual Performance Objective | | | | | |
| Annual Indicator | | | 5.8 | 5.8 | 5.8 |
| Numerator | | | | | |
| Denominator | | | | | |
| Is the Data Provisional or Final? | | | | Provisional | Provisional |
| | **2005** | **2006** | **2007** | **2008** | **2009** |
| Annual Performance Objective | 5.8 | 5.8 | 5.8 | 5.8 | 5.8 |

**Notes - 2002**

Because only one of the States (Maine) met the NCHS standards for reliability for PM 6, the 2002 indicator is the national average except for Maine which has its State value noted.

**Notes - 2003**

The data reported in 2002 have pre-populated the data for 2003 for this performance measure.

**Notes - 2004**

The data reported in 2004 are pre-populated with the data from 2003 for this performance measure.

a. Last Year's Accomplishments

During FY04, there was a strong, sustained commitment within the CYSHCN Program and the C&Y Branch to provide a greater focal point for transition services and diffuse transition responsibilities. As anticipated, one of the vacant positions in the SSU was redefined as a Transition Program Consultant position. This position was designated as the lead for implementation of NPM 6 and for engaging collaborators within and external to the WCHS in addressing this NPM. An individual with strong public health background and experience in health disparities as they affect youth began in late April 2004.

The Transition Program Consultant conducted Key Informant Interviews. Interviews in DPH focused on programs that impact YSHCN. State and local partner interviews included leaders in the DSS Foster Care Programs; Division of MH/DD/SAS; NCODH; local school systems; non-profit agencies that serve youth and families in transitioning from school to work; vocational specialists; and an assistive technology specialist. The interviews yielded a broad perspective of services that impact YSHCN and served to develop vital connections for future

collaboration along with ideas on future program initiatives.

Other positions in the C&Y Branch, such as the Family Liaison Specialist, the Health Choice Program Manager for CYSHCN, and the NCODH Program Manager, continue to have transition as a component of their job responsibilities.

The SSU continued to benefit from the expertise, health communications, and technical assistance resources of the NCODH program. NCODH provided consultation to WCHS staff on the ADA and universal design of health care, fitness and health promotion environments. Adult disability consultants and staff in NCODH participated in the planning of transition related initiatives, to further ensure a disability focus shaped by principles of independent living and self-determination. NCODH staff provided consultation and technical assistance to the NC DD Council as it developed demonstration efforts in youth leadership and access to health care. Additional emphasis on working with the School Health Program and other C&Y Branch initiatives to increase their ability and effectiveness in including youth with disabilities within state and community health promotion and health education activities continued. This included risk reduction initiatives such as obesity prevention and promotion of physical activity.

Activities to promote medical homes for CYSHCN continued to include a focus on transition. Baseline data from the National Survey for CYSHCN was used in planning transition efforts and in further galvanizing support for addressing health transition.

The SSU continued to use the DHHS focus on Eliminating Health Disparities as a platform for disseminating information and technical assistance regarding strategies for improving outreach, access, and inclusion of the disability population.

**Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet**

| Activities | Pyramid Level of Service | | | |
|---|---|---|---|---|
| | DHC | ES | PBS | IB |
| 1. Provide a greater focal point for transition, as well as diffuse transition responsibilities across the C&Y Branch. | | | | X |
| 2. Include transition component in the job descriptions of several positions being filled in C&Y Branch. | | | | X |
| 3. Continue NCODH training and TA to WCHS re: ADA, universal design, fitness, and health promotion environments. | | | | X |
| 4. Staff provides TA on youth leadership development to the NC Developmental Disabilities Council. | | | | X |
| 5. Collaborate with the School Health Program to include youth with disabilities when planning activities. | | | | X |
| 6. Activities to promote medical homes for CSHCN will focus on transition. | | | | X |
| 7. Continue to use the National Survey of Children with Special Health Care Needs data in planning transition efforts and galvanizing support. | | | | X |
| 8. DHHS Eliminating Health Disparities Initiative. | | | | X |
| 9. | | | | |
| 10. | | | | |

b. Current Activities

The current year's focus has been on continuing to build partnerships, gather data for the

MCHB Needs Assessment, give presentations to stakeholders on national and state data, and gain information on the health of youth in transition.

Participating in the Champions for Progress multi-state meeting presented another opportunity for skill building. Information gained at the meeting on the use of the national data source was used to develop presentations to state agencies on the status of C/YSHCN.

The Transition Program Consultant presented the national data to the NC Commission on CSHCN. Also, data was presented to the DPH School Health Matrix Team. The purpose was to offer on overview of the data and to promote inclusion of YSHCN needs in relevant school health programs. School Health then requested information and materials developed for a school health conference. The Transition Program Consultant was asked to participate on a regular basis on the School Health Matrix. Other important outcomes include reviewing School Based/School Linked grants and site visits to the centers.

One of the major projects for the Transition Program Consultant has been the development of the Interagency Collaborative on Youth in Transition. This group represents agencies that serve youth ages 13-21. Key partners include: NC Links Program (youth leadership for foster youth), Department of Juvenile Justice and Delinquency Prevention, a local homeless shelter, Division of Vocational Rehabilitation Services, Communities in Schools (non-profit), a youth leader from SAYSO (Strong Stable Youth Speaking Out), DMH/DD/SAS, an Independent Living Program, and the Teen Pregnancy Prevention Initiative. The Transition Program Consultant facilitates the group which is developing their action plan for the year. The following is information from the action plan draft:
Mission: To strengthen inter-agency collaboration that better supports transition age youth to function as independent, healthy adults.
Population served: Youth ages 13-21 facing chronic challenges that require additional public support to develop their ability to achieve self-sufficiency.
Goals:
-Share information throughout the system from state, local to service provider levels
-Identify overlaps and gaps in services
-Assess agencies' abilities and obtain commitment to stretch toward filling those gaps
-Promote inter- and intra-agency collaboration to improve the provision of needed services

Another major focus of the Transition Program Consultant is to work with the contractor staff at UNC Center for Development and Learning LEND Program to obtain data for the MCHB Needs Assessment. The Transition Program Consultant co-facilitated the focus groups and worked with the contractors to identify the available data sources. Initial feedback from the focus group shows a strong need to focus on the services available to youth transitioning to adulthood.

## c. Plan for the Coming Year

Plans for FY06 focus mostly on information gained from the MCHB Block Grant Needs Assessment to address outstanding needs for youth in transition. The focus will be on Infrastructure Services such as training, policy development, community development, and information services. Population-based services include public awareness campaigns of programs and policies that would impact youth and their families. Another major focus will be to continue the leadership of the Interagency Collaborative and implement some of the identified projects. One such potential project is to contact all agencies with youth leadership programs and develop a Youth Advisory Council which will not involve creating a new youth program, but will utilize these youth in an advisory capacity for Title V. The Transition Program Consultant will continue to provide training and technical assistance to agencies and organizations on promoting healthy transitions for YSHCN.

The vacant NCODH positions (Director and Program Manager) will be filled in April 2005. It is

anticipated that the NCODH will continue to provide consultation and technical assistance to the NC DD Council as it further develops demonstration efforts in youth leadership development and access to health care. Additional emphasis will be placed on working with the regional Physical Therapy staff on the initiatives of physical activity and nutrition, oral health and improving the health of children/youth in the foster care system.

The SSU is anticipating filling the vacant Health Choice for Special Needs position in FY06 and will be reviewing utilization of Health Choice for youth as they transition out of that program into adult services. In addition, the vacant Nutrition position should be filled and issues for physical activity and obesity prevention will be linked to this staff member. This will include close work with the School Health Unit in their focus on obesity prevention and promotion of physical activity.

Performance Measure 07: *Percent of 19 to 35 month olds who have received full schedule of age appropriate immunizations against Measles, Mumps, Rubella, Polio, Diphtheria, Tetanus, Pertussis, Haemophilus Influenza, and Hepatitis B.*

Tracking Performance Measures
*[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]*

| Annual Objective and Performance Data | 2000 | 2001 | 2002 | 2003 | 2004 |
|---|---|---|---|---|---|
| Annual Performance Objective | 90 | 90 | 90 | 90 | 90 |
| Annual Indicator | 80.6 | 80.6 | 80.7 | 85.6 | 86.2 |
| Numerator | | | | | |
| Denominator | | | | | |
| Is the Data Provisional or Final? | | | | Final | Final |
| | **2005** | **2006** | **2007** | **2008** | **2009** |
| Annual Performance Objective | 90 | 90 | 90 | 90 | 90 |

**Notes - 2002**

FY2002 data are from the National Immunization Survey. As this is a weighted estimate, data for the numerator and denominator are omitted.

In FY02, prior data based on 4:3:1 rates were replaced with 4:3:1:3:3 rate data per the National Immunization Survey. FY96 though FY98 is actually based on CY data, but data are reported for FY from FY99 though FY01. As these data are taken from the NIS, actual numerators and denominators are not available.

**Notes - 2003**

FY2003 data are from the National Immunization Survey. As this is a weighted estimate, data for the numerator and denominator are omitted.

**Notes - 2004**

FY2004 (July 1, 2003 to June 30, 2004) data are from the National Immunization Survey. As

this is a weighted estimate, data for the numerator and denominator are omitted.

## a. Last Year's Accomplishments

The FY04 National Immunization Survey results showed that NC coverage remained high as 86.2% of children in the target age group were fully immunized (4:3:1:3:3). The staff of the Immunization Branch (IB) continues to work to raise this rate. Activities undertaken in FY04 included work with LHDs to raise rates by using the Clinical Assessment Software Application files that are sent bi-monthly. Also, LHDs were encouraged to use Baby-Track files, provided by the state office to start tracking children who are 12-18 months old during the upcoming year. In addition, Assessment, Feedback, Incentives and eXchange (AFIX) visits were done in private provider offices to help increase rates in the private sector, which would translate to higher rates overall in the public sector. Practices with lower rates were given suggestions for achieving higher rates based on best practices from offices that had rates of >=90%. By the end of FY04, AFIX visits had been made in all 100 counties. LHDs and private providers were encouraged to use the Provider Access to Immunization Registry Securely (PAiRS) database, which links records from public and private sources in a database accessible through secure Internet connections. The IB, in collaboration with the Division of Information Resource Management (DIRM), drafted an RFP for the modification of the Wisconsin Immunization Registry (WIR). The RFP detailed the modifications needed for the WIR to meet the needs of North Carolina's Universal Childhood Vaccine Distribution Program (UCVDP) and was place on competitive bid in February 2004. In preparation for the new registry, staff members continued working with local health department staff on "registry readiness" activities. In addition, the IB continued a contract with the NC Pediatric Society to hire nurses and a physician to do registry promotion in private provider offices throughout NC.

**Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet**

| Activities | Pyramid Level of Service | | | |
|---|---|---|---|---|
| | DHC | ES | PBS | IB |
| 1. Maintenance of the Universal Childhood Vaccine Distribution Program. | | | X | |
| 2. LHD assessment and tracking activities. | | | | X |
| 3. Complete at least 150 AFIX visits in calendar year 2005. | | X | | |
| 4. Update the new Immunization Branch web site as necessary. | | | X | |
| 5. Continue to offer the interim registry solution PAiRS to providers. | | | | X |
| 6. Complete deployment of the statewide registry to the remaining 96 local health departments. Begin deployment to private providers. | | | | X |
| 7. | | | | |
| 8. | | | | |
| 9. | | | | |
| 10. | | | | |

## b. Current Activities

During FY05, the contract to modify the WIR for the development of the North Carolina Immunization Registry (NCIR) was awarded to EDS, and work began in July 2004. Milestones 1, 2, 3, and 4 of development will be completed by the end of FY05. Full system development is scheduled to be completed in October 2005. The pilot phase for the NCIR began in February 2005. Pilot participants include public and private providers in four counties: Chatham, Pitt, Henderson, and Cabarrus. The pilot is scheduled to last three months. Of the 56 public and private providers in the four counties, 38 are participating in the pilot. In addition to system use, the pilot requires providers to participate in pilot feedback activities. The IB will use the data collected to improve statewide system deployment efforts which are scheduled to begin in July

2005. In preparation for this deployment, IB staff members continue recruitment and registry readiness efforts with non-pilot participants throughout the state.

### c. Plan for the Coming Year

During FY06, the IB will begin statewide deployment efforts for the new NCIR. Extensive efforts will be made to transition the local health departments of the remaining 96 counties from the existing mainframe registry to the new NCIR by December 31, 2005. Ongoing activities meant to help increase immunization coverage rates will continue.

## Performance Measure 08: *The rate of birth (per 1,000) for teenagers aged 15 through 17 years.*

Tracking Performance Measures
*[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]*

| Annual Objective and Performance Data | 2000 | 2001 | 2002 | 2003 | 2004 |
|---|---|---|---|---|---|
| Annual Performance Objective | 39 | 38.5 | 32 | 32 | 30 |
| Annual Indicator | 37.2 | 32.7 | 30.4 | 28.6 | 26.9 |
| Numerator | 5275 | 5080 | 4726 | 4589 | 4377 |
| Denominator | 141681 | 155309 | 155551 | 160414 | 163003 |
| Is the Data Provisional or Final? | | | | Final | Final |
| | **2005** | **2006** | **2007** | **2008** | **2009** |
| Annual Performance Objective | 26.5 | 26 | 26 | 25.5 | 25 |

**Notes - 2002**

FY year data are actually the prior calendar year, e.g. FY02 is really CY01.

**Notes - 2004**

FY year data are actually the prior calendar year, e.g. FY04 is really CY03.

### a. Last Year's Accomplishments

Teen pregnancy and birth rates continue to decline in NC, consistent with the national trend. In 2003, the fertility rate was 26.9 per 1000 for teens (ages 15-17) as compared with 28.6 in 2002. The pregnancy rate declined to 36.0 as compared with 38.3 in 2002. In FY04, the Teen Pregnancy Prevention Initiative (TPPI) funded a total of 61 projects through a combination of state appropriations, TANF, and Medicaid funds. In addition to the 30 primary teen pregnancy prevention projects, TPPI also funds 31 secondary pregnancy prevention programs that target pregnant and parenting teens using a single model intervention best described as a youth development/mentoring model. While the primary focus of the Adolescent Parenting Program (APP) is in reducing unintended pregnancies among pregnant teens, it is also focused on promoting parenting skills, preventing child abuse and neglect, and ensuring high school graduation among its participants. The Adolescent Pregnancy Prevention Program (APPP) continued to emphasize the use of best practice models in primary pregnancy prevention

among its 30 funded projects in 2004. In this year's application process, the TPPI program prescribed 14 best practice models. Applicants are strongly encouraged, though not required, to use the prescribed models. Finally, the Family Planning and Reproductive Health Unit (FPRHU) continues to collaborate with the state Department of Public Instruction (DPI) in the implementation of the statewide abstinence education program funded with Section 510 MCHB Abstinence Education Funds. Although the Section 510 grant was recently transferred from the MCHB to the Youth and Family Services Bureau of the Administration for Children and the Family, the FPRHU is still the official grantee agency for the Section 510 MCHB grant until the end of this current funding cycle. However, state legislation mandates the transfer of Section 510 funds to DPI to supplement the implementation of an existing statewide abstinence education program in local schools.

**Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet**

| Activities | Pyramid Level of Service | | | |
|---|---|---|---|---|
| | DHC | ES | PBS | IB |
| 1. Ongoing support provided for the Teen Pregnancy Prevention Initiative projects. | | X | | |
| 2. Primary prevention projects participate in annual evaluation process. | | | | X |
| 3. All TPPI projects participate in a web-based process evaluation program. | | | | X |
| 4. Annual Teen Pregnancy Prevention Symposium (with Adolescent Pregnancy Prevention Coalition of NC) | | | | X |
| 5. Annual Adolescent Parenting Graduation Conference. | | | | X |
| 6. | | | | |
| 7. | | | | |
| 8. | | | | |
| 9. | | | | |
| 10. | | | | |

## b. Current Activities

While teen pregnancy and birth rates in NC continue to decline, a number of challenges remain. Data from the 2003 NC Youth Risk Behavior Survey (most current info available) suggest that NC youth continue to engage in behaviors that put them at risk for unintended pregnancies and sexually transmitted diseases. Survey results show that 52% have ever had sexual intercourse; 17% of adolescents surveyed have ever had four or more sex partners; 38% of adolescents surveyed have had sexual intercourse during the past three months and the same number did not use a condom during last sexual intercourse; and 82% of female adolescents surveyed did not use birth control pills during last sexual intercourse. National studies, however, have suggested that the continuing decline in teen pregnancies can be attributed to increasing numbers of teens delaying first intercourse and increased use of contraception among those who are sexually active.

In addition to continuing the current initiatives under TPPI, there is also an ongoing emphasis in DPH in identifying and implementing interventions to reduce racial disparities in health indicators, including teen pregnancies and sexually transmitted diseases. As a first step, FPRHU staff has formulated objectives for local grantees that specifically address the reduction and elimination of health disparities in their respective programs. These objectives, based on the DPH's health disparities reduction plan, are formally included as part of the scope of work in the contractual agreement between the state and the local providers in the current fiscal year.

c. Plan for the Coming Year

Rule changes resulting from legislative action in 2002 will continue to be implemented for the program. The TPPI program will search for additional funding to support Hispanic/Latino teen pregnancy prevention initiatives. The TPPI program plans to implement an Annie E. Casey initiative Plain Talk for FY06. The RFA proposal process in fall 2004 resulted in one proposal suitable for funding in FY06. Funding this particular Plain Talk project will add to the two existing projects the state is targeting for teen pregnancy reduction among Hispanic populations. In addition, as a supplement to the Title X renewal application currently being submitted for FY06, the Planned Parenthood of Central North Carolina is attaching their application for a special Title X initiative grant to support the implementation of Joven a Joven. Based on the Teen Voices model, this peer mentoring, peer education program has been tailored to meet the needs of Hispanic/Latino population in Durham County. Consequently, TPPI has an opportunity to address ethnic and racial disparities among Hispanic/Latino youth by building a bridge of collaboration between state government, local government agencies, private organizations, and local Hispanic-focused efforts. Efforts to identify specific program objectives that address reductions in racial disparities in health indicators at the local level will continue. The FPRHU will support the funding of agencies to provide teen pregnancy prevention programs using best practice models which demonstrate proven means of reducing unintended teen pregnancies. Program evaluation activities, a requirement for all TPPI projects, will continue. The FPRHU will also continue to develop its response to a new Title X mandate to incorporate the "ABC" concept in the program's HIV/AIDS education and teen pregnancy prevention initiatives.

The FPRHU will continue to place greater emphasis on recruiting teen patients. The number of teens served has been declining in the last three years. The number of teens served by the family planning program in CY04, (36,176) declined by 8% compared to CY03. However, 73% of the teens enrolled in the program are using more effective methods of contraception, the pill and Depo Provera.

Performance Measure 09: *Percent of third grade children who have received protective sealants on at least one permanent molar tooth.*

Tracking Performance Measures
*[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]*

| **Annual Objective and Performance Data** | **2000** | **2001** | **2002** | **2003** | **2004** |
|---|---|---|---|---|---|
| Annual Performance Objective | 50 | 50 | 50 | 50 | 50 |
| Annual Indicator | 34.3 | 37.0 | 37.0 | 37 | 41.0 |
| Numerator | 29151 | 30603 | 32668 | | 31452 |
| Denominator | 84892 | 82710 | 88293 | | 76711 |
| Is the Data Provisional or Final? | | | | Provisional | Final |
| | **2005** | **2006** | **2007** | **2008** | **2009** |
| Annual | | | | | |

| | | | | | |
|---|---|---|---|---|---|
| Performance Objective | 50 | 50 | 50 | 50 | 50 |

**Notes - 2002**

These data are based on fifth graders, not third graders. In North Carolina, the surveillance system used to measure the percentage of elementary school children who have received protective sealants on at least one permanent molar tooth was set up to measure fifth graders before the national standard was set at third graders. Data collected in an epidemiologic survey conducted in 1986-87 did not show a statistically significant difference between the percentage of third graders and the percentage of fifth graders.

Beginning in FY02, these date will only be available every other year as efforts are being redirected from annual surveillance activities to promote an increase in the number of sealants placed.

**Notes - 2003**

37% is just an estimate based on the data from 2002. School year data was not collected in FY03 on the proportion of children who have dental sealants because of budget restraints, but should be available for FY04. As part of state supported sealant promotion projects in cooperation with volunteer private practitioners, the Oral Health Section provided 20,272 sealants for 5,364 children

**Notes - 2004**

These data are based on fifth graders, not third graders. In North Carolina, the surveillance system used to measure the percentage of elementary school children who have received protective sealants on at least one permanent molar tooth was set up to measure fifth graders before the national standard was set at third graders. Data collected in an epidemiologic survey conducted in 1986-87 did not show a statistically significant difference between the percentage of third graders and the percentage of fifth graders.

Beginning in FY02, these date will only be available every other year as efforts are being redirected from annual surveillance activities to promote an increase in the number of sealants placed.

## a. Last Year's Accomplishments

Last school year, data was collected on 76,711 (73 percent) fifth grade children. The proportion who have dental sealants was 41 percent. This is an increase from 28 percent in 1996. As part of state supported sealant promotion projects in cooperation with volunteer private practitioners and using Preventive Health and Health Services Block Grant funding, the Oral Health Section provided 7,137 sealants for 1,650 children during 42 sealant projects. This level of activity was reduced due to the time commitment required for the statewide dental survey of children to evaluate our community-based preventive programs. Educational exhibits promoting the use of sealants were used with 571 adults.

**Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet**

| Activities | Pyramid Level of Service | | | |
|---|---|---|---|---|
| | DHC | ES | PBS | IB |
| 1. Statewide dental assessment of oral health status conducted in alternate school years (even years). | | | | X |
| 2. Staff driven and community-based sealant projects conducted. | X | | | |
| 3. Educational services provided in various settings. | | | X | |
| 4. | | | | |
| | | | | |

| | | | | |
|---|---|---|---|---|
| 5. | | | | |
| 6. | | | | |
| 7. | | | | |
| 8. | | | | |
| 9. | | | | |
| 10. | | | | |

b. Current Activities

This year, the Oral Health Section will once again focus on providing dental sealants for children at high-risk for dental decay. With funding from the Preventive Health and Health Services Block Grant, we plan to provide 20,000 sealants. The educational exhibits will continue to be used by staff to educate parents and decision-makers about dental sealants.

c. Plan for the Coming Year

Plans for the coming year are uncertain. Funding that allows the sealant projects and use of the educational exhibits comes from the Preventive Health and Health Services Block Grant, which the President has targeted for elimination. If these funds are lost, the Section does not have replacement funds to allow these activities.

Performance Measure 10: *The rate of deaths to children aged 14 years and younger caused by motor vehicle crashes per 100,000 children.*

Tracking Performance Measures
*[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]*

| **Annual Objective and Performance Data** | **2000** | **2001** | **2002** | **2003** | **2004** |
|---|---|---|---|---|---|
| Annual Performance Objective | 3.5 | 3 | 5.5 | 5 | 5 |
| Annual Indicator | 4.9 | 5.9 | 5.6 | 5.3 | 4.5 |
| Numerator | 77 | 99 | 94 | 90 | 78 |
| Denominator | 1560534 | 1671411 | 1682289 | 1706584 | 1717971 |
| Is the Data Provisional or Final? | | | | Final | Final |
| | **2005** | **2006** | **2007** | **2008** | **2009** |
| Annual Performance Objective | 4 | 4 | 4 | 4 | 4 |

**Notes - 2002**

In June 2001 all annual indicators for this measure (1991 - 2000) were revised to reflect the new age group (<14 years versus age 1 to 14) as indicated on the detail sheet with the guidance for the FY02 Block Grant. Data are for the calendar year preceding the fiscal year. In August of each year, the NC Office of State Planning releases certified population estimates for North Carolina and its counties as of July 1 of the previous year. These estimates represent

annual average resident population rather than the population on that date.

## a. Last Year's Accomplishments

The rate of deaths due to motor vehicle crashes for children <=14 years old declined to 4.54% in 2003, which is a .8 reduction from 2002. The local Child Fatality Prevention Teams (CFPT) provided full-team reviews on 100 deaths and submitted reports to the state Team Coordinator. To increase child safety efforts, the North Carolina House proposed a new "Booster Seat" law. The North Child Fatality Task Force (NCCFTF) was instrumental in conducting the research needed to assess the problem and advocate to the NC General Assembly to get this law passed in 2004. Although NC had a previous booster seat law, the task force saw the need to strengthen this law based on recommendations from national experts such as the National SAFE KIDS Campaign.

**Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet**

| Activities | Pyramid Level of Service | | | |
|---|---|---|---|---|
| | DHC | ES | PBS | IB |
| 1. Continued review of child deaths due to motor vehicle crashes on the state and local levels. | | | | X |
| 2. Enactment of the Graduated Drivers License Restriction law. | | | | X |
| 3. Community car seat distribution programs. | | X | | |
| 4. | | | | |
| 5. | | | | |
| 6. | | | | |
| 7. | | | | |
| 8. | | | | |
| 9. | | | | |
| 10. | | | | |

## b. Current Activities

During FY05, the local CFPT reviewed deaths of children <= 14 caused by motor vehicle crashes. As of January 1, 2005, NC has a new child passenger safety law. Previously, NC law required child booster seats to be used until a child reached five years or forty pounds. The new law requires children to use either a child seat or booster seat until eight years or eighty pounds. Penalties for violating the law will include a $25 fine and two points on the driver's license. Local CFPT will continue current activities in FY05 including support for the new booster seat law.

## c. Plan for the Coming Year

A total of 23 children died as a result of accidents involving all terrain vehicles between the years 1999-2002 in NC. The typical victims involved in ATV crashes were white, male, and between 11-15 years of age. Typically, victims were not wearing protective headgear, were unsupervised, and were riding a four-wheel vehicle on private property.

The local CFPT support the efforts of the NCCFTF to enact news law surrounding the operation of ATV (All Terrain Vehicles). Several counties including Pasquotank, Pitt, and Davidson, have contacted the task force to lend any support that is needed to enact an ATV Safety Law. The local teams which support the enactment of this law made the following specific recommendations: 1) introduce legislation on ATV use by children requiring an age limit, weight/height requirements; 2) apply penalties for parents who do not abide by the law; 3)

require the use of helmets while riding an ATV; and 4) increase education on ATV use and the laws concerning ATV use.

Based on recommendations from the NCCFTF, Senate Bill 189 has been introduced to the NC General Assembly. This bill would increase the safety of children by: 1) restricting the age of children who can ride with or without supervision of an adult; 2) restricting the carrying of passengers except on vehicle designed by the manufacturer to carry passengers; 3) restricting the sale of ATV to certain age groups; 4) requiring the passage of a safety certificate indicating successful passage of an ATV safety course; and 5) providing a financial penalty for those who violate the law.

Performance Measure 11: *Percentage of mothers who breastfeed their infants at hospital discharge.*

Tracking Performance Measures
*[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]*

| Annual Objective and Performance Data | 2000 | 2001 | 2002 | 2003 | 2004 |
|---|---|---|---|---|---|
| Annual Performance Objective | 75 | 75 | 75 | 75 | 75 |
| Annual Indicator | 43.0 | 44.5 | 46.3 | 46.7 | 48.2 |
| Numerator | 31566 | 33517 | 34656 | 34592 | 36422 |
| Denominator | 73456 | 75384 | 74811 | 74043 | 75575 |
| Is the Data Provisional or Final? | | | | Final | Final |
| | **2005** | **2006** | **2007** | **2008** | **2009** |
| Annual Performance Objective | 50 | 55 | 60 | 65 | 70 |

**Notes - 2002**

Unable to determine if breastfed infants are "exclusively" breastfed.
Data from WIC program.

**Notes - 2003**

Unable to determine if breastfed infants are "exclusively" breastfed.
Data from WIC program.

**Notes - 2004**

Unable to determine if breastfed infants are "exclusively" breastfed.
Data from WIC program on women participating in WIC, not population based.

a. Last Year's Accomplishments

The breastfeeding initiation rate of women participating in WIC in FY04 was 48.2%, which is a 1.5% increase over FY03 (46.7%). Specific activities undertaken in FY04 to increase breastfeeding rates included co-sponsoring the NC Lactation Educator Training Program (NCLETP) which had 74 participants and obtained 59.5 continuing education credits (L-Cerps) from the International Board Certified Lactation Consultant Examiners (IBCLCE) toward the

Board Certification for completing this course; distributing an additional 166 hospital strength pumps, 97 pedal pumps and 6382 manual pumps and accessory kits to local WIC Programs; continuing a free-of-charge Vitamin D (Tri-Vi-Sol Vitamins A, C & D) drops distribution program for infants and children who are at least 6 weeks old, breastfeeding and not receiving more than 12 ounces of infant formula or milk daily; providing training to 200 Child and Adult Care Food Program (CACFP) sponsors and child care providers via a teleconference on "How to Support Breastfeeding in Child Care Centers"; providing training to 80 local and regional WIC and community leaders on Breastfeeding Peer Counselor Programs; and providing professional resources and educational materials to local WIC agencies for professional use and client distribution.

**Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet**

| Activities | Pyramid Level of Service | | | |
|---|---|---|---|---|
| | DHC | ES | PBS | IB |
| 1. Support the efforts of Breastfeeding Peer Counselor Programs. | | X | | |
| 2. Promote and recognize World Breastfeeding Week. | | | X | |
| 3. Offer the North Carolina Lactation Educator Training Program. | | | | X |
| 4. Seek nominations for "Mother-Friendly Business Leaders". | | | | X |
| 5. Distribute electric breast pumps and accessory kits to local WIC agencies. | | X | | |
| 6. Enhance and support accurate breastfeeding data collection and analysis. | | | | X |
| 7. Maintain a free-of-charge Vitamin D program for infants (>=6 weeks) and mostly breastfeeding. | | X | | |
| 8. Provide client education materials & professional resources including training | | | X | |
| 9. Training and consultation targeted toward childcare industry on breastfeeding and pumped breastmilk. | | | | X |
| 10. Complete a North Carolina plan for promoting and supporting breastfeeding. | | | | X |

b. Current Activities

The following strategies were implemented in FY05 to support increasing breastfeeding initiation and duration rates: co-sponsoring the NCLETP which had 62 participants and obtained 59.5 continuing education credits (L-Cerps) from the IBCLCE toward the Board Certification for completing this course; distributing an additional 112 hospital strength pumps, and 4700 manual pumps and accessory kits to local WIC Programs and 30 pedal pumps; continuing a free-of-charge Vitamin D drops distribution program for infants and children who are at least 6 weeks old, breastfeeding and not receiving more than 12 ounces of infant formula or milk daily; provided training to 185 CACFP sponsors and child care providers via a teleconference on "How to Support Breastfeeding in Child Care Centers"; developing a state breastfeeding plan entitled "North Carolina Blueprint for Action: Promoting and Supporting Breastfeeding through Policy and Environmental Changes"; developing state plans for funding and implementing the USDA Loving Support Breastfeeding Peer Counselor Model in WIC Programs; and providing professional resources and educational materials to local WIC agencies for professional use and client distribution. The state breastfeeding plan was developed by first organizing a 15 member statewide task force representing non-governmental and public agencies to identify essential North Carolina breastfeeding stakeholders and to develop the vision, mission, agenda for a public breastfeeding forum. This public forum was

convened in September 2004 and was attended by 145 North Carolina breastfeeding stakeholders who assisted in the development of recommendations and strategies for the promotion and support of breastfeeding.

### c. Plan for the Coming Year

New activities planned for FY06 include: distributing and promoting the implementation of activities identified in the "North Carolina Blueprint for Action: Promoting and Supporting Breastfeeding through Policy and Environmental Changes" with the intent for children in North Carolina to start life breastfeeding, the best possible foundation for optimal infant and young child feeding; organizing a WIC Program breastfeeding coordinator meeting to address local WIC Program breastfeeding needs; implementing the USDA Loving Support Breastfeeding Peer Counselor Program model with new funding, program policies, and training; distributing a self-study manual on "Breastfeeding Pumps Issuance and Loaning Guidelines" to local WIC agencies; and continuing the following on-going breastfeeding support activities: co-sponsoring NCLETP; maintaining the free-of-charge Vitamin D distribution program; distributing additional hospital strength electric breast pumps and accessory kits to local WIC Programs; promoting World Breastfeeding Week and recognizing "Mother-Friendly" Business Leaders; distributing educational materials to local WIC agencies for professional use and client distribution; supporting accurate breastfeeding data collection and analysis; and promoting breastfeeding support activities in child care agencies.

## Performance Measure 12: *Percentage of newborns who have been screened for hearing before hospital discharge.*

Tracking Performance Measures
*[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]*

| Annual Objective and Performance Data | 2000 | 2001 | 2002 | 2003 | 2004 |
|---|---|---|---|---|---|
| Annual Performance Objective | 75 | 85 | 95 | 95 | 99 |
| Annual Indicator | 73.0 | 86.5 | 85.6 | 87.6 | 87.8 |
| Numerator | 85408 | 101937 | 102196 | 102988 | 103985 |
| Denominator | 116997 | 117885 | 119372 | 117501 | 118493 |
| Is the Data Provisional or Final? | | | | Final | Final |
| | **2005** | **2006** | **2007** | **2008** | **2009** |
| Annual Performance Objective | 90 | 90 | 95 | 95 | 95 |

**Notes - 2002**

Universal newborn hearing screening program was implemented in calendar year 2000.

FY data are actually from the previous calendar (e.g., FY03 data is really CY02). The denominator is provided by the State Laboratory and the denominator for resident live births differs somewhat from the denominator used in outcome measures and other performance

measures where the data are obtained from Vital Records.

Although NC had previously reported that over 99% of infants born in the state receive newborn hearing screenings prior to discharge from the birthing facility (an over reporting), a more sophisticated statistical analysis strategy was implemented in FY05 and used on current and past data and the procedures will be applied to data analysis plans in the future. Data for 2000, 2001, and 2003 have been updated using the new methodology.

**Notes - 2003**

Universal newborn hearing screening program was implemented in calendar year 2000.

FY data are actually from the previous calendar (e.g., FY03 data is really CY02). The denominator is provided by the State Laboratory and the denominator for resident live births differs somewhat from the denominator used in outcome measures and other performance measures where the data are obtained from Vital Records.

Although NC had previously reported that over 99% of infants born in the state receive newborn hearing screenings prior to discharge from the birthing facility (an over reporting), a more sophisticated statistical analysis strategy was implemented in FY05 and used on current and past data and the procedures will be applied to data analysis plans in the future. Data for 2000, 2001, and 2003 have been updated using the new methodology.

**Notes - 2004**

Universal newborn hearing screening program was implemented in calendar year 2000.

FY data are actually from the previous calendar (e.g., FY03 data is really CY02). The denominator is provided by the State Laboratory and the denominator for resident live births differs somewhat from the denominator used in outcome measures and other performance measures where the data are obtained from Vital Records.

Although NC had previously reported that over 99% of infants born in the state receive newborn hearing screenings prior to discharge from the birthing facility (an over reporting), a more sophisticated statistical analysis strategy was implemented in FY05 and used on current and past data and the procedures will be applied to data analysis plans in the future. Data for 2000, 2001, and 2003 have been updated using the new methodology.

## a. Last Year's Accomplishments

All 94 hospitals/birthing facilities continued to provide newborn hearing screening, and an increased number used the website for their quarterly reports. Annual monitoring of hospital programs continued. The number of hospitals doing their own re-screening continued to increase. A Unit Manager was hired for the Genetics and Newborn Screening Unit, which combines newborn hearing screening, newborn metabolic screening, genetic counseling, genetic services, and birth defects monitoring programs.

Data from a survey of audiologists in the state were presented to the Early Hearing Detection and Intervention (EHDI) Advisory Board. These data were used to develop content for a grant application to CDC for funds for a conference focused on 1) timely and appropriate referrals and 2) involving families in decision-making about their child's hearing loss intervention. The EHDI Advisory Board has a formal chair. Speech Language and Audiology Consultants shared information with providers about Assistive Technology and Children's Special Health Services Program and reviewed speech and hearing requests for both these programs as well as for the Health Choice Program. Presentations at the Child Health Nurses Training continued.

Collaboration among Unit staff on issues of genetics and hearing loss was begun, with presentations made to inter-agency partners for genetic referral protocols. In addition, collaboration for identifying children at risk for late onset hearing loss was begun. Training and

otoacoustic emissions (OAE) hearing screening equipment was provided to Early Head Start/Migrant Head Start Centers through a grant with the National Center for Hearing Assessment Management.

**Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet**

| Activities | Pyramid Level of Service | | | |
|---|---|---|---|---|
| | DHC | ES | PBS | IB |
| 1. Enhancements to the Newborn Hearing Screening Data Tracking and Surveillance System. | | | X | |
| 2. Technical support to the local newborn hearing screening programs in birthing/neonatal facilities. | | | | X |
| 3. Identification of needs and training opportunities for pediatric audiologists. | | | | X |
| 4. Regional staff ensuring that all infants have access to screen and rescreen. | X | | | |
| 5. Infants tracked through screening, evaluation and amplification process to assure no children are missed. | | X | | |
| 6. | | | | |
| 7. | | | | |
| 8. | | | | |
| 9. | | | | |
| 10. | | | | |

b. Current Activities

One hospital stopped being a birthing facility and consequently stopped newborn hearing screenings. The other 93 hospitals/birthing facilities continued their newborn hearing screening programs and quarterly reporting. Annual monitoring of those programs by the Speech Language and Audiology Consultants are continuing. Two Audiology Consultant positions and a Program Manager position were filled in 2004. The Program Manager has extensive experience working in state government as a Speech Language Pathology Consultant, providing consultation to families and professionals and developing and conducting training. In addition, a contract Speech Language Consultant position was filled in February 2005. The EHDI Advisory Board is reviewing its mission statement and developing goals and objectives.

With the support of a CDC grant, a database is being developed for web-based entering of individual child data into a statewide tracking system. The pilot of this web-based entering of data began in February 2005 with the participation of six (6) birthing facilities. Enhancements are being made to a PowerPoint presentation used with the Child Health Nurses Training by the Speech Language Consultants. Through state funds, OAE hearing screening equipment was purchased and distributed to local health departments for use in hearing screening on children birth-21 of age through periodic well child checks and/or when a hearing loss is suspected. Regional Child Health Speech Language and Audiology Consultants are providing OAE training to identified personnel in the majority of local health departments across the state.

Through grant funds received from the CDC, North Carolina's EHDI Conference was scheduled for April 2005. Speech Language and Audiology Consultants continue to provide reviews of Assistive Technology, Children's Special Health Services, and Health Choice requests. A portion of the MCHB Newborn Hearing Screening Grant funds have been targeted to

development of an overall program evaluation plan and evaluation of current data as well as data gathered during the grant period. Summarized data from this evaluation will be used in reviewing and developing outcome measurements. Although NC had previously reported that over 99% of infants born in the state receive newborn hearing screenings prior to discharge from the birthing facility (an over reporting), a more sophisticated statistical analysis strategy is now being used on current data and the procedures will be applied to data analysis plans in the future. This statistical analysis strategy revealed that 87.8% of infants were screened before hospital discharge in 2003. Similarly, 87.6% of infants were screened before hospital discharge in 2002, and 85.6% of infants in 2001.

### c. Plan for the Coming Year

In the coming year, hospitals/birthing facilities will continue their newborn hearing screening programs and quarterly reporting. Annual monitoring of those programs will continue. Formal agreements for collaborative consultant efforts and for referring children identified with permanent hearing loss to early intervention resources are underway. Enhancements will continue with the web-based entering of individual child data into NC data system, the Hearing Link. A new CDC grant application has been completed that would support the development of a plan to take the enhanced web-based entering of individual child data into a statewide tracking system. A grant application for "Monitoring Children with Hearing Loss in a Medical Home" was submitted to MCHB in November 2004. If these grant funds are received, technical assistance, training, and equipment will be provided to selected Community Access Care Networks.

The EHDI Advisory Board will continue to review its purpose, membership, and function in order to better strengthen and support the overall EHDI Program. The program evaluation plan will be used to provide ongoing guidance, and the data reported in the EHDI process will be continued to be analyzed with an emphasis placed on enhancing the reporting of data for diagnosis, amplification, and intervention services. Recommendations from the program evaluation will be reviewed, and a plan for implementation will be developed. Consideration will be given to a formal mechanism/process for receiving routine feedback from partners and consultees.

Speech Language and Audiology Consultants will continue to provide review of Assistive Technology, Children's Special Health Services, and Health Choice requests. Enhanced presentations to the Child Health Nurses Training will continue.

Collaboration on genetics/hearing loss and on identifying children at risk for late onset hearing loss will continue. The training/equipment efforts for OAE hearing screening will continue in the local health departments as well as in the Early Head Start/ Migrant Head Start Centers.

## Performance Measure 13: *Percent of children without health insurance.*

Tracking Performance Measures
*[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]*

| Annual Objective and Performance Data | 2000 | 2001 | 2002 | 2003 | 2004 |
|---|---|---|---|---|---|
| Annual Performance Objective | 11 | 10 | 10 | 9 | 9 |
| | | | | | |

| | | | | | |
|---|---|---|---|---|---|
| Annual Indicator | 10.4 | 11 | 11.1 | 12.3 | 12.8 |
| Numerator | 205494 | | 242660 | 267020 | 276660 |
| Denominator | 1977723 | | 2181520 | 2177890 | 2156720 |
| Is the Data Provisional or Final? | | | | Final | Final |
| | **2005** | **2006** | **2007** | **2008** | **2009** |
| Annual Performance Objective | 10 | 10 | 10 | 9 | 9 |

**Notes - 2002**

Data for FY02 are based on pooled March 2001 and 2002 Current Population Surveys estimates. Data for both years are provided by the Urban Institute and Kaiser Commission on Medicaid and the Uninsured.

Data for FY01 are based on pooled March 2000 and 2001 Current Population Surveys estimates. Numerator and denominator are not available.

The methodology described below was repeated to obtain FY00 data. Population estimates for 2000 were used and the number of Medicaid and Health Choice eligibles was determined as of September 2000.

New methodology for FY 99: The number of uninsured was estimated for children in six age/income cells -- age was divided into two categories (less than 6 and 6-18), and income was divided into three categories (<200% FPL, 201-300% and > 300%). In each age category, the total number of children was based on 1999 population estimates from the Office of State Planning. These numbers were distributed across the income cells within each age category based on the income distribution found in the combined 1997, 1998 and 1999 CPS. We subtracted:
1) the actual number of Medicaid eligibles in September 1999;
2) the actual number of Health Choice eligibles in the month of Speptember 1999; and
3) the estimated number of children covered by other non-Medicaid sources of insurance.
The remainder is our estimate of the number of uninsured. There is no comparable data for FY98. Data for this measure are taken from North Carolina's "Annual Report of the State Children's Health Insurance Plans under TItle XXI of the Social Security Act" and there are no data available for FY98 in these reports.

Data for FY98 are not available. Objectives were not set at that time, either.

**Notes - 2003**

FY03 Data Source: Urban Institute and Kaiser Commission on Medicaid and the Uninsured estimates based on pooled March 2002 and 2003 Current Population Surveys for children <18.

**Notes - 2004**

FY04 Data Source: Urban Institute and Kaiser Commission on Medicaid and the Uninsured estimates based on pooled March 2003 and 2004 Current Population Surveys for children <18.

## a. Last Year's Accomplishments

By July 1, 2003, 100,436 children were enrolled in the NC Health Choice (NCHC) Program, and an additional 110,193 children were enrolled in the Medicaid for Infants and Children Program since SCHIP began in October 1998. During FY04, there was no enrollment freeze. However, 2002-03 data from the Kaiser Family Foundation showed that 12% of children ?18 years old in NC remained uninsured. An NCIOM report documents the lack of reliability of

these data, but certainly recent economic downturns have negatively impacted this measure. Recommendations made by the NCIOM NCHC Task Force in early 2003 were implemented, with the exception of moving children ages 0-5 with family incomes <=200% FPL into Medicaid and their Primary Care Gatekeeper Model of Managed Care.

In FY04, changes were enacted to institutionalize outreach and improve communication. A list serve was developed that includes about 700 key state and local partners, enhancing our capacity to provide targeted communications and broadcast our electronic newsletter. In November 2003, the WCHS, through work with the NCHSF, launched the HC/NCHC Outreach Website (www.nchealthystart.org/outreach). The website's goal is to be a one-stop shop of information to help local staff and their outreach partners and provide a forum for sharing outreach experiences. Evidence of success is that local staff began networking with each other for technical assistance. Another initiative done with the NCHSF and Community Care of NC was the development of educational materials to support a statewide Medical Home Campaign to be launched in FY05. With diversified funding and partners, the campaign will promote the concept of a primary care medical home for both well and sick care; provide education about inappropriate use of the Emergency Room; and instructs parents, particularly those with a child with special health care needs, on how to "Make Each Doctor's Visit Work for You."

In October 2003, a person was hired to target HC/NCHC outreach to minority populations, to help the C&Y Branch with administering programs in a culturally competent manner, and to work on WCHS efforts to eliminate health disparities. This position has had a huge impact by networking with a wide variety of state, regional and community-based organizations and minority media outlets who serve the Latino, American Indian and Hmong communities. GIS mapping is used to target outreach activities to areas with high densities of minority populations. This position was also involved in the development of a pilot faith-based lay health advisor program.

The WCHS continued to sustain efforts to market HC/NCHC, operate the NC Family Health Resource Line and the Special Needs Helpline, and support the work of the RWJ and Rex Foundation grant-funded initiatives. The WCHS has also been involved in state Medicaid efforts to create family-friendly, low literacy, Title VI-compliant notices and forms and improve the data available to state and local staff.

**Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet**

| Activities | Pyramid Level of Service | | | |
|---|---|---|---|---|
| | DHC | ES | PBS | IB |
| 1. Maintain HC/NCHC Outreach Campaign through the NC Healthy Start Foundation. | | | X | |
| 2. Maintain NC Family Health Resource Line as a bilingual informational telephone hotline. | | | X | |
| 3. Maintain HC/NCHC Outreach web site. | | | X | |
| 4. Maintain HC/NCHC educational campaign regarding medical home/ER use/preventive care. | | | X | |
| 5. Develop Medical Home educational campaign for children with special health care needs | | | X | |
| 6. Support grant-funded initiatives: NC Covering Kids and Families and Wake Rex Foundation Project | | | | X |
| 7. Simplification of enrollment/re-enrollment forms and development of family-friendly notices. | | X | | |

| | | | | |
|---|---|---|---|---|
| 8. Development of comparable data sets for HC and NCHC | | | | X |
| 9. Targeted outreach to special populations (including minority and CSHCN). | | | X | |
| 10. | | | | |

## b. Current Activities

By July 1, 2004, 115,571 children were enrolled in the Health Choice Program, and an additional 145,165 children had been enrolled in the Medicaid since SCHIP began in October 1998. However, 2003-04 data from the Kaiser Family Foundation indicated that 13% of children <=18 years old in NC remain uninsured. A freeze on new enrollment was threatened in early FY05, but the NCGA appropriated an additional $6.6 million and DHHS moved additional monies into NCHC to keep the program open. The NCIOM NCHC Task Force recommendation to move children ages 0-5 into Medicaid is again being considered by the state legislature.

The Medical Home Campaign, launched in July 2005, is similar in scope and target audiences to the launch of the NCHC Program back in 1998, with one significant difference being the access to list serves and the ability to hyperlink to the HC/NCHC website resulting in a faster distribution of information. Nearly 1,000,000 Medical Home educational materials were distributed in the first 6 months.

In FY05, a focal point for HC/NCHC and the Medical Home Campaign has been a renewed effort toward targeted outreach to CYSHCN. Information has been disseminated through targeted mailings, list serves, presentations, and exhibits. In addition, new materials are under development, including the NCHC Booklet, "Information for Children with Special Health Care Needs and their Families," and a business card promoting the services offered through the Specialized Services Help Line. The SSU, in partnership with the Community Care of NC program and the UNC Center for Health Care Quality Improvement, is launching pilot projects to develop provider capacity to serve as medical homes for CYSHCN. WCHS, partnering with the NCHSF and the Family Support Network of NC, is developing family-focused medical home materials to complement this effort, including "Choosing a Quality Medical Home" and "Resources for CYSHCN". A "Care Notebook" is also being considered to incorporate "CYSHCN Care Plans." The NCHC CSHCN consultant position is soon to be filled after a budgetary delay.

Targeted outreach to minority populations continues to be a major focus of the Campaigns as WCHS works with sister agencies on Title VI compliance issues, efforts to eliminate health disparities, and culturally competent outreach strategies and materials. The HC/NCHC Minority Outreach consultant continues to have a tremendous impact with her involvement in policy development and targeted community outreach. WCHS and the NCHSF partnered with Univision (the only NC Latino TV Station) to develop 7 PSAs promoting the importance of a medical home and health insurance for children. A Fotonovella (story book) is also being created that will help Latino families understand the American health care system.

## c. Plan for the Coming Year

In FY06, a continued focal point for HC/NCHC will be targeted outreach to CYSHCN. With the hiring for the NCHC CSHCN consultant position expected in FY05, a work plan will be developed to institutionalize and sustain outreach to the CYSHCN population. The data required to support ongoing analysis/evaluation will be assessed and routine access requested.

The Medical Home Campaign will print, promote and distribute new materials, developed during FY05, to support families of CYSHCN. These materials will complement parallel efforts in the practice community. Pilot projects to develop provider capacity to serve as Medical

Homes for CYSHCN, spearheaded by the SSU, in partnership with the Community Care of NC Program and the UNC Center for Health Care Quality Improvement, will continue.

Targeted outreach to minority populations will also continue to be a major focus of the Campaigns. Work with state, regional and community-based organizations and minority media outlets will continue.

An ongoing focus will be to sustain efforts that assure children's access to comprehensive health insurance and quality medical homes.

Performance Measure 14: *Percent of potentially Medicaid-eligible children who have received a service paid by the Medicaid Program.*

Tracking Performance Measures
*[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]*

| Annual Objective and Performance Data | 2000 | 2001 | 2002 | 2003 | 2004 |
|---|---|---|---|---|---|
| Annual Performance Objective | 96 | 97 | 98 | 90 | 90 |
| Annual Indicator | 99.2 | 96.1 | 86.1 | 86.8 | 87.4 |
| Numerator | 695956 | 726979 | 688080 | 727653 | 766054 |
| Denominator | 701891 | 756858 | 799360 | 837949 | 876866 |
| Is the Data Provisional or Final? | | | | Final | Final |
| | **2005** | **2006** | **2007** | **2008** | **2009** |
| Annual Performance Objective | 90 | 90 | 90 | 90 | 90 |

**Notes - 2002**

The methodology for determining data for this measure changed for FY02 data. In year's past, any claim was counted, but this year, claims which did not include provider contact were eliminated, thus the percentage decreased quite a bit from previous years. Detailed explanation of new methodology follows:

For Federal Fiscal 2002 (10/1/2001-09/30/2002) the number of under 21 XIX enrolled at some point with the year was 799,360.

Under 21 receiving an XIX service, excluding those for which the ONLY claims were the system generated claims to pay the Carolina Access Fees or the Health Check Coordinator Prorated Salaries was 688,080. Under 21 HMO fees were INCLUDED.

Under 21s for whom a claim was paid whether an actual service or a system generated premium or fee was 780,886.

Denominator changed for FY 97 and FY 98 to accurately reflect the number of children that were eligible for Medicaid. The previous number was reflective of all uninsured children that

were below 200% of the Federal poverty rate.

**Notes - 2003**

The methodology for determining data for this measure changed starting with FY02 data. In years past, any claim was counted, but beginning with FY02 data, claims which did not include provider contact were eliminated, thus the percentage decreased quite a bit from previous years.

**Notes - 2004**

The methodology for determining data for this measure changed starting with FY02 data. In years past, any claim was counted, but beginning with FY02 data, claims which did not include provider contact were eliminated, thus the percentage decreased quite a bit from previous years.

## a. Last Year's Accomplishments

The lifting of the hiring freeze for Health Check Coordinators in April 2003 meant that counties could recruit staff for new and vacant positions. As of May 2004, 88 of 100 counties offered HCC services. There were 117 HCCs statewide with the number of positions per county varying based on the number of Medicaid-eligible children. The primary job responsibility for an HCC continued to be assuring that Medicaid recipients accessed preventive health screenings. To curb emergency room use, HCCs followed-up with ER mis-users, educating parents about the importance of using their child's Medical Home for routine preventive and primary care visits. Also, in most counties the HCCs were the lead contacts for HC/NCHC outreach. In FY03, there were 837,949 children enrolled in Medicaid, an increase of more than 40% over the past decade since the Health Check Program was enhanced by HCCs and the Automated Information and Notification System to improve program enrollment and participation in well child care. With the recent downturn in the economy, NC's seamless approach to HC/NCHC outreach, enrollment and reenrollment has paid off as children moved back and forth between the two programs as their family incomes fluctuated.

HCCs continued to be an integral part of state planning in relation to HC/NCHC. They, along with family representatives, provided assistance with the development and enhancement of campaign materials through surveys and/or focus groups. HCCs were integral to the development of a suite of materials to support a statewide Medical Home Campaign to be launched in FY05. It was understood that the new materials would be of tremendous value to HCCs as they follow-up with families who misuse the ER. The three primary diagnoses involved when children use the ER inappropriately - fever, ear infections, and colds and flu -- are all specifically addressed in the Medical Home materials.

HCCs also served on the committee that assisted the state in the development of the HC/NCHC Outreach Website (www.nchealthystart.org/outreach). Through information they provided in an Annual HC/NCHC Outreach Survey, the website is being used to share local contact information and "lessons learned".

WCHS supported this work by:
-Serving as the lead agency for HC/NCHC outreach;
-Contracting with the NCHSF for their campaign, materials and website development expertise;
-Developing a list serve of HCCs, their supervisors and state staff to hot link staff to "New News" posted on the HC/NCHC Outreach Website;
-Administering, through a contract with UNC, the NC Family Health Resource Line (our state toll-free Title V line and the "action step" in all HC/NCHC materials);
-Participating in quarterly introductory trainings for HCC staff and providing technical assistance in relation to general and targeted minority outreach activities; and
-Contributing to the development of state EPSDT policies and drafts of the annual "Health Check Billing Guide."

**Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet**

| Activities | Pyramid Level of Service | | | |
|---|---|---|---|---|
| | DHC | ES | PBS | IB |
| 1. Statewide distribution of Health Check Coordinators based on a reallocation of existing positions. | | X | | |
| 2. Use of AINS by HC Coordinators to track and follow Medicaid-eligible children. | | | | X |
| 3. Grassroots community outreach to promote enrollment in HC/NCHC. | | | X | |
| 4. Link families who have utilized the ER for non-emergent care to their medical home. | | | | X |
| 5. | | | | |
| 6. | | | | |
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| 8. | | | | |
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| 10. | | | | |

b. Current Activities

As of March 2005, 88 of 100 counties plus the Qualla Boundary (Cherokee Indian Tribe) in NC offered HCC services. There are currently 107 HCC positions statewide. The number of positions per county varies based on the number of Medicaid-eligible children. The number of positions that can be hired is frozen so new counties can only be added if a position is vacated in one county where there are multiple HCCs, and the decision is made to move that position to another county based on the relative number of Medicaid-eligible children. In FY04, there were 876,866 Medicaid eligible children with 87% receiving at least one service during that time period.

In FY05, a major initiative has been the launch of our HC/NCHC Medical Home Campaign. Although the state-level marketing effort has been extensive, HCCs are the primary users of the materials. It is a perfect fit as they do community outreach for HC/NCHC, promote access to a medical home for preventive services, and follow-up with families who misuse the ER for routine primary care services. Nearly 1,000,000 Medical Home educational materials were distributed in the first 6 months of FY2005 thanks largely to their efforts.

Another focused effort for WCHS has been targeted outreach to minority populations and to families of CSHCN. Through introductory trainings for new staff, regional meetings, an annual meeting, list serve/website news and day to day technical assistance, HCCs will be updated and involved in these targeted outreach efforts.

HCCs are a critical part of the solution to our overall goal to institutionalize and sustain outreach for publicly-funded children's health insurance programs. They are the one stable factor in our community-based grassroots outreach. Initially, with the kick-off of our SCHIP, local communities formed HC/NCHC Outreach Coalitions with diverse representation. Many of these local coalitions met for a few years and then faded away. A goal for WCHS has been to encourage HCCs to link with community based organizations and existing community coalitions that share the mission to reduce the number of uninsured. Healthy Carolinians Coalitions, whose focus is the achievement of Healthy People 2010 Objectives, is a good option in some communities.

HCCs are also critical to the continued development and success of our HC/NCHC Outreach

Website. They are realizing the power of this medium for local sharing and for keeping abreast of programmatic changes and updates.

In FY05, WCHS continued to support the work of HCCs by maintaining the activities listed in the report of accomplishments for FY04.

### c. Plan for the Coming Year

In FY06, HCCs will continue to be a critical part of the solution to our overall goal to institutionalize and sustain outreach for publicly-funded children's health insurance programs. They will also assure that once children are insured, they will have access to preventive and primary care services provided in a medical home.

A continued focal point in the coming year will be targeted outreach to CYSHCN. The Medical Home Campaign is currently developing educational materials to link families of CYSHCN to the resources they need, to help them choose a quality medical home, and to support their efforts to become full partners in the care of their child. The materials will complement parallel efforts in the practice community where pilot projects will encourage primary care providers to become quality medical homes for CYSHCN. HCCs will continue to be critical to the success of these and other family outreach efforts.

HCCs will also be critical to the continued development and success of our HC and NCHC Programs as outreach materials are updated, new materials are developed, "lessons learned" are communicated through the outreach website, and as general and targeted outreach activities are planned.

## Performance Measure 15: *The percent of very low birth weight infants among all live births.*

Tracking Performance Measures
*[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]*

| Annual Objective and Performance Data | 2000 | 2001 | 2002 | 2003 | 2004 |
|---|---|---|---|---|---|
| Annual Performance Objective | 1.8 | 1.8 | 1.7 | 1.7 | 1.7 |
| Annual Indicator | 1.9 | 1.9 | 1.9 | 1.9 | 1.8 |
| Numerator | 2186 | 2309 | 2293 | 2175 | 2118 |
| Denominator | 113755 | 120247 | 118112 | 117307 | 118292 |
| Is the Data Provisional or Final? | | | | Final | Final |
| | **2005** | **2006** | **2007** | **2008** | **2009** |
| Annual Performance Objective | 1.7 | 1.7 | 1.7 | 1.7 | 1.7 |

**Notes - 2002**

FY year data are actually the prior calendar year, e.g. FY02 is really CY01.

**Notes - 2004**

FY year data are actually the prior calendar year, e.g. FY02 is really CY01.

## a. Last Year's Accomplishments

The percent of very low birth weight infants has remained at about 1.8% over the past few years. Several different maternal health programs are focused on improving perinatal health outcomes, including low birth weight.

The WCHS continues to focus on evaluating and enhancing the service provision of the state's Baby Love Program, specifically the Maternity Care Coordination (MCC) and Maternal Outreach Worker (MOW) components. During FY04, the Baby Love Best Practices Pilot implemented a new risk factor screening and needs assessment process for MCC and MOW services in 11 local provider agencies. This standardized process has helped focus resources and efforts on those individuals with the greatest needs and has improved the quality of MCC and MOW service provision. The utilization of the new standardized care planning process, Pathways of Care for MCC has increased the assurance that effective interventions are being implemented by the programs. The pathways were updated in 3 practice areas (Smoking Cessation Counseling, Mental Health, and Violence Against Women) to reflect current best practice assessment and intervention techniques. Pilot agency staff also received specialized training in addressing depression in women.

NC continues to have 4 federally-funded Healthy Start Programs Baby Love Plus (BLP), 3 of which are coordinated through the state Title V agency -- Eastern, Northeastern, and Triad Baby Love Plus. Fourteen counties are covered by BLP and 3 additional counties are part of Healthy Start Corps. During FY04, the BLP sites provided intensive outreach to >75,000 people, with the primary focus being African American and American Indian families. Other accomplishments include:
-The 6th Annual Healthy Start Training Institute was held in July and attracted 325 participants from the 3 BLP project regions.
-Family Leadership Development Retreats, designed to strengthen the family and community advocacy skills, were held in each region with 195 participants attending.
-Triad BLP Ministry of Health Initiative continued with 15 churches participating in the training sessions. The faith-based health promotion effort is designed to focus on healthy lifestyles for pregnant women and women of childbearing age and their families.
-15 Lay Health Advisors (LHAs) completed training on improving the health of pregnant women and women of childbearing age. The LHAs are barbers and beauticians within the region.
-10 participants completed phase one of the African American Cultural Diversity Curriculum train-the-trainer program.

NC's Minority Infant Mortality Reduction Program, Healthy Beginnings, funded 13 local community-based organizations to focus on perinatal health disparities. The sites continue to partner with the Healthy Start sites in continuing education efforts.

**Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet**

| Activities | Pyramid Level of Service | | | |
|---|---|---|---|---|
| | DHC | ES | PBS | IB |
| 1. Collaborate with March of Dimes and NCHSF to reduce prematurity and low birth weight. | | | | X |
| 2. Work with MIMRP sites to develop lessons learned and best practices. | | | | X |
| 3. Provide combined skillbuilding training for MIMRP, Baby Love Plus, and Healthy Start Corps. | | | | X |
| | | | | |

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## b. Current Activities

The Baby Love Best Practices Pilot is continuing in its second and final year. The new risk-screening process was integrated into the 11 pilot agencies' services and is improving the ability of the agencies to focus their services on the clients who have the most significant needs. An evaluation of the assessment and care planning process is being conducted to determine any necessary revisions prior to the development of a final recommended statewide model. The new required home visiting component has enhanced service provision and is being continued by the pilot agencies.

Clients of the pilot agencies identified transportation access, language barriers, and clinic hours as barriers to receiving needed services. Standard best practice formats are being used to address issues such as early prenatal care, nutrition, smoking cessation, pyschosocial issues, and substance use, and to aid staff in individualizing each plan of care. Pilot agency staff also received training on case management for high-risk medical conditions and assessing risk for potential child maltreatment.

Highlights of the Healthy Start BLP efforts include:
-The Triad site hired a part-time Consumer Advocate.
-The 7th Annual Healthy Start Training Institute was held in July with 400 participants.
-Phase two of the African American Cultural Diversity Curriculum train-the-trainer program is in progress.
-The Ministry of Health Initiative is being developed for the Northeastern BLP Program.
-The Eastern BLP Region conducted a Family Violence Community Forum with 100 providers.
-Local and state project staff and contracted partners participated in the annual Building Bridges training.
-BLP webpage development -- www.ncbabyloveplus.org

Five Targeted Infant Mortality Reduction Program sites were selected through a request for applications process. This program is designed to conduct community-wide efforts to reduce infant morbidity and mortality. Five additional sites received planning funding to conduct comprehensive needs assessments and received intensive technical assistance, training, and support and are competing for an implementation grant.

A new Perinatal Substance Use Specialist was hired in the fall of 2004. The position is co-funded by DPH and DMH/SA/DD and housed at the NC Family Health Resource Line. One of her activities has been to create and disseminate an outreach flyer containing service information and a listing of specialized perinatal/maternal treatment programs in NC. She met with staff from the majority of treatment programs and made presentations to over 450 public health providers about accessing treatment services. The Responding to Perinatal Substance Use, A Guide for Local Health Departments, 2000 manual is being updated and posted on the web. Information about bed availability at the perinatal/maternal residential treatment programs is tracked and disseminated weekly.

## c. Plan for the Coming Year

The Baby Love Best Practices Pilot evaluation will be completed and the results shared with local providers and other state agencies. The implementation of a recommended standard protocol for MCC and MOW services provision by all Baby Love Program providers will be encouraged. The protocol will include a risk-screening process, standardized needs assessment, care planning process with recommended best practice interventions, and a monitoring and follow-up system. This intent of this process is to increase the focus on women at higher risk for poor birth outcomes or infant mortality, and to ensure that the Baby Love Program MCC and MOW services can provide effective interventions to address client needs.

The Pathways of Care for Maternity Care Coordination will be updated in specific content areas to appropriately address new best practice guidelines for preventing violence against women and child maltreatment, and an other content areas with new guidelines presented during the year. Training will be offered to local Baby Love program staff on these updates to their service provision to pregnant and postpartum women.

The bi-annual Baby Love Conference is planned for August 2005. This skillbuilding effort is focused on MCH providers throughout the state.

The Baby Love Plus site plans include:
-Triad Baby Love Plus Ministry of Health continuing education sessions.
-Northeastern Baby Love Plus Ministry of Health training and continuing education sessions
-Partnership with Healthy Beginnings, TIMR and Healthy Start Corps to hold the annual Building Bridges training. The conference serves as a skillbuilding and networking effort for community-based perinatal health advocates.
-Family Leadership Development Retreats in all three regions.
-Board Development training for Regional Consortiums in all three regions.

As part of the state's efforts to reduce smoking among pregnant women, all local health department prenatal care providers will be required to counsel women who smoke utilizing the 5A best practice method -- ask, advise, assess, assist, and arrange. The Perinatal and Neonatal Outreach Education Trainers (POETs/NOETs) will provide leadership in training local staff. The POETs/NOETs are highly trained and skilled nurse educators affiliated with universities, medical schools, and area health education centers (AHECs) in the state.

WCHS also has plans for developing a comprehensive plan for women of childbearing age and tobacco use efforts. Part of this plan will be based on the findings from the statewide provider survey.

A Perinatal/Maternal Substance Use database is being created to more effectively log perinatal substance use calls at the NC Family Health Resource line, as well as manage treatment program related information. Continued outreach and education is planned for the coming year, along with the resurrection of a provider newsletter, Awakenings.

Performance Measure 16: *The rate (per 100,000) of suicide deaths among youths aged 15 through 19.*

Tracking Performance Measures
*[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]*

| Annual Objective and Performance Data | 2000 | 2001 | 2002 | 2003 | 2004 |
|---|---|---|---|---|---|
| | | | | | |

| | | | | | |
|---|---|---|---|---|---|
| Annual Performance Objective | 6 | 5 | 5 | 5 | 5 |
| Annual Indicator | 8.8 | 7.1 | 8.7 | 5.2 | 7.4 |
| Numerator | 45 | 38 | 49 | 30 | 43 |
| Denominator | 510687 | 535356 | 560336 | 572740 | 581841 |
| Is the Data Provisional or Final? | | | | Final | Final |
| | **2005** | **2006** | **2007** | **2008** | **2009** |
| Annual Performance Objective | 6 | 6 | 5 | 5 | 5 |

**Notes - 2002**

FY year data are actually the prior calendar year, e.g. FY02 is really CY01.

**Notes - 2003**

**Notes - 2004**

FY year data are actually the prior calendar year, e.g. FY02 is really CY01.

## a. Last Year's Accomplishments

During FY04, a six-month follow-up evaluation was conducted with the participants of the six regional workshops held in the spring of 2003 to ascertain how the information was used and any long lasting effects. A survey was also conducted to monitor the progress of the newly certified Livingworks Trainers.

The Youth Suicide Prevention Task Force (YSPTF) published their Executive Summary in April 2004 called "Saving Tomorrows Today: North Carolina's Plan to Prevent Youth Suicide." The plan issues the following recommendations: 1) promote awareness that suicide is a public problem that is preventable; 2) develop and implement community-based suicide prevention programs; 3) implement training for recognition of at-risk behavior and delivery of effective treatment; 4) promote efforts to reduce access to lethal means and methods of self harm; 5) improve access to linkages with community mental health and substance abuse services; and 6) improve and expand surveillance systems.

The YSPTF received plan endorsements from 34 professional, non-profit, and community organizations. The LivingWorks trainers who were certified in FY03 conducted Applied Suicide Intervention Skills Training (ASIST) workshops throughout the state. Eleven workshops were provided from July 1, 2003 and June 30, 2004. The Department of Juvenile Justice and Delinquency Prevention, which sent two staff members to become trained, has developed their own training schedule to educate departmental staff in suicide awareness/intervention. The NCCFTF continues to take part in the work of the YSPTF and supports their prevention plan.

**Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet**

| Activities | Pyramid Level of Service | | | |
|---|---|---|---|---|
| | **DHC** | **ES** | **PBS** | **IB** |
| 1. Livingworks Training conducted. | | | | **X** |
| 2. Development of a surveillance plan. | | | | **X** |
| | | | | |

| | | | | |
|---|---|---|---|---|
| 3. Development and implementation of a listserve. | | | | X |
| 4. | | | | |
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| 7. | | | | |
| 8. | | | | |
| 9. | | | | |
| 10. | | | | |

## b. Current Activities

The number of suicides for the age group 15-19 in NC for 2003 was 43. This is 7.39% of the total population for that age group. To increase awareness of the issue of child suicide The Child Fatality Task Force will present a request for youth suicide prevention funding to the legislature on behalf on the YSPTF. The YSPTF is requesting $225,000 to continue work in promoting suicide awareness and gatekeeper training throughout NC.

This year federal legislation appropriated a total of $11.5 million for youth suicide prevention. The grant will be administered by SAMHSA and the RFA process will begin in April. Only one entity in a state can receive and award. The YSPTF will hold a meeting of key stakeholders on March 21st in order to garner cooperation and consensus about North Carolina's effort to receive grant funding.

The complete state youth suicide prevention plan was published in October 2004. The report was placed on-line and can be accessed through the Injury and Violence Prevention Branch web page (http://www.communityhealth.dhhs.state.nc.us/injury.htm).

Work of the task force was communicated through exhibits at three large professional conferences and two half-day presentations in two school districts. The chairperson of the YSPTF also participates in the School Health Matrix Team in order to promote addressing self-injurious behavior issues in the school setting. Three members of the YSPTF also participate in a newly formed community group the Triangle Consortium for Suicide Prevention.

Eight LivingWorks trainers were able to receive required training upgrades within the state through the task force's collaboration with Fort Bragg which was conducting training for the military.

The Epidemiology Unit of the Injury and Violence Prevention Branch (lead agency of the YSPTF) has been implementing the NC Violent Death Reporting System. The chairperson of the YSPTF is part of their Data User's Advisory Board. A draft of the first six month implementation results were shared with the board. An annual report will be released next year. Data will provide more descriptive information about individuals who die by suicide.

The Mental Health Association in NC, a member of the YSPTF, obtained funding to organize the first state suicide prevention conference in March 2005.

## c. Plan for the Coming Year

It is hoped that NC will receive either a federal grant and/or a state grant to implement goals of the youth suicide prevention plan. Implementation of these strategies will require even greater cooperation between agencies.

If no funding is received, the YSPTF will continue to seek support of agencies to implement goals of the plan which are applicable to a particular agency's area of work.

The NC Violent Death Reporting System will continue to operate. The data generated will be available to organizations who can use the information for strategic planning purposes.

Implementation and management of the state-wide list serve in order to create an informative and supportive network for exchange of ideas about youth suicide prevention will be performed by the Injury and Violence Prevention Branch.

The YSPTF will continue to build a network of agencies (professional, non-profit, faith-based) across the state that are interested in youth suicide prevention.

Performance Measure 17: *Percent of very low birth weight infants delivered at facilities for high-risk deliveries and neonates.*

Tracking Performance Measures
*[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]*

| Annual Objective and Performance Data | 2000 | 2001 | 2002 | 2003 | 2004 |
|---|---|---|---|---|---|
| Annual Performance Objective | 82 | 82 | 82 | 83 | 83 |
| Annual Indicator | 79.8 | 81.8 | 79.6 | 78.1 | 80.2 |
| Numerator | 1532 | 1600 | 1562 | 1447 | 1450 |
| Denominator | 1920 | 1956 | 1963 | 1852 | 1808 |
| Is the Data Provisional or Final? | | | | Final | Final |
| | **2005** | **2006** | **2007** | **2008** | **2009** |
| Annual Performance Objective | 83 | 83 | 83 | 83 | 83 |

**Notes - 2002**

These data include deliveries at 12 facilities originally designated for high-risk deliveries and neonates back in the 1980s. There are other hospitals within the state with NICUs whose deliveries are not included in this count.

FY year data are actually the prior calendar year, e.g. FY02 is really CY01.

**Notes - 2004**

These data include deliveries at 12 facilities originally designated for high-risk deliveries and neonates back in the 1980s. There are other hospitals within the state with NICUs whose deliveries are not included in this count.

FY year data are actually the prior calendar year, e.g. FY02 is really CY01.

a. Last Year's Accomplishments

The Neonatal Bed Locator Service continued to provide 24 hour per day, 7 day per week, 365 day per year service to physicians and hospitals to ensure that the most appropriate level of

care bed space was secured for neonates.

The Neonatal Outreach and Education Trainers (NOETs) and Perinatal Outreach and Education Trainers (POETs) continue to educate providers on this service and other issues of importance of very low birth weight infants born in tertiary centers. During FY04, over 7,700 health care and human service providers from across the state received training through this program.

The High Risk Maternity Clinic Program continued to fund programs in 13 local health departments and 4 tertiary care centers to assure that women in need of high risk maternity services receive risk-appropriate prenatal care and deliver in hospitals with Neonatal Intensive Care Units.

**Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet**

| Activities | Pyramid Level of Service | | | |
|---|---|---|---|---|
| | DHC | ES | PBS | IB |
| 1. Implementation of contract with Wake Forest University for Neonatal Bed Locator services. | | | | X |
| 2. Continual review of data to access sites more likely to keep low birthweight babies. | | | | X |
| 3. | | | | |
| 4. | | | | |
| 5. | | | | |
| 6. | | | | |
| 7. | | | | |
| 8. | | | | |
| 9. | | | | |
| 10. | | | | |

## b. Current Activities

From July 1, 2004 through February 28, 2005, the Neonatal Bed Locator Service had 513 total calls for requests to locate neonatal and maternal bed space.

The NOETs' primary focus areas continue to include: substance abuse (includes smoking); breastfeeding; resuscitation and stabilization; the care and discharge of convalescing newborns; and the promotion of best practices in neonatal care.

The High Risk Maternity Program is working with High Risk Maternity Clinics with identified "best practices" to share these practices via phone conferences every 6 months. At these phone conferences, those exemplary clinics are asked to report on certain aspects that can help the others, as well as serving as a way to clarify issues concerning high risk pregnancy management.

## c. Plan for the Coming Year

During the upcoming year, the Neonatal Bed Locator service will continue to provide a 24 hour per day, 7 day per week, 365 day per year service to field calls to locate neonate and maternal bed space in NC hospitals.

Also, a list serve will be developed to share information pertinent to High Risk Maternity Clinic managers and staff in the coming year.

Performance Measure 18: *Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester.*

Tracking Performance Measures
*[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]*

| Annual Objective and Performance Data | 2000 | 2001 | 2002 | 2003 | 2004 |
|---|---|---|---|---|---|
| Annual Performance Objective | 85 | 86 | 86 | 87 | 87 |
| Annual Indicator | 84.5 | 84.0 | 83.9 | 83.7 | 83.7 |
| Numerator | 96079 | 100988 | 99092 | 98226 | 99039 |
| Denominator | 113755 | 120247 | 118112 | 117307 | 118292 |
| Is the Data Provisional or Final? | | | | Final | Final |
| | **2005** | **2006** | **2007** | **2008** | **2009** |
| Annual Performance Objective | 87 | 87 | 87 | 87 | 87 |

**Notes - 2002**

Data for this indicator for 2001 differ from HSCI#5c because this indicator is based on CY2000 data and HSCI#5c is really CY2001 data., which matches the FY02 (CY01) data in this indicator.

FY year data are actually the prior calendar year, e.g. FY02 is really CY01.

**Notes - 2004**

FY year data are actually the prior calendar year, e.g. FY02 is really CY01.

a. Last Year's Accomplishments

The NC Family Health Resource Line (MCH Hotline) worked in conjunction with the First Step Campaign to continue to answer questions from callers about pregnancy and getting appropriate prenatal care. The First Step Campaign, which is administered by the NC Healthy Start Foundation, distributed educational materials to consumers, healthcare providers and childcare providers. The materials developed and disseminated include information focused on prematurity and low birthweight issues, evidence-based practices on disparity in perinatal health, and awareness of safe sleep practices to help decrease infant mortality in NC. They include Thanks for Asking, an informational piece about stress and pregnancy; Providing Hope for a Brighter Future, a brochure specific to Sickle Cell Disease and trait along with Folic Acid reminder items designed specifically for the 18-24 year old female population; and a Spanish Back to Sleep Light Switch Cover for new parents and child caregivers (Spanish speakers). The First Step Campaign focused on increasing public awareness and developing private and public partnerships at the state level with the goal of improving the health status of mothers and babies in NC.

The federally funded Healthy Start Baby Love Plus sites, along with the Healthy Beginnings sites, continued to provide intensive outreach and client recruitment services in 23 counties. The sites employ a combination of Outreach Workers and Community Health Advocates who are specially trained members of the community. They continued to serve as a bridge between the health care providers and consumers of service. They provide community outreach door-to-door, through house parties, and through other venues. Over 60,000 individuals were served during FY04 with outreach and educational messages.

The Baby Love Plus Ministry of Health and Lay Health Advisor efforts also contributed to this effort. Through training and sharing information with faith-based entities, along with barbers and beauticians, additional families were educated and made aware of local resources and services.

**Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet**

| Activities | Pyramid Level of Service | | | |
|---|---|---|---|---|
| | DHC | ES | PBS | IB |
| 1. Maternity Care Coordination and Maternal Outreach Worker programs ongoing. | | X | | |
| 2. Re-application process for Minority Infant Mortality Reduction Projects. | | | | X |
| 3. Continued outreach through Baby Love Plus with a focus on perinatal women's health. | | X | | |
| 4. Work with Sickle Cell Program to educate families of childbearing age on perinatal health issues | | | | X |
| 5. 10-county pilot project with MCCs and MOWs. | | X | | |
| 6. | | | | |
| 7. | | | | |
| 8. | | | | |
| 9. | | | | |
| 10. | | | | |

b. Current Activities

The First Step Campaign has continued to promote the NC Family Health Resource Line (MCH Hotline) and encouraged women to seek early and continuous prenatal care services. The Campaign's current focus is on prematurity and low birthweight issues, evidence-based practices on disparity in perinatal health, and awareness of safe sleep practices. During this state fiscal year, educational and promotional materials which address the impact of infant mortality, racial disparity, low birthweight and prematurity on families and the state are being developed and narrowed in focus. They will be completed by June 2005. A new educational material is being developed that will address the interconceptional time period and related desired behaviors that increase the chance of having a subsequent healthy pregnancy. A Spanish Sickle Cell Program brochure was developed as well as a Spanish language brochure, No Fume Aqui, for teens about secondhand smoke. The NC Healthy Start Foundation website has been updated to include expanded information about the First Step Campaign such as minority infant mortality reduction issues and efforts, smoking cessation, annual infant mortality/morbidity statistics, low birthweight and prematurity, wellness for women of reproductive years (i.e., positive preconceptional and interconceptional health behaviors), and parenting/child development. The website has also been revamped for Spanish speakers, which included identifying appropriate links to Spanish websites and featuring relevant

information for Latinos. Updates and reprints have been completed for: NC Healthy Start Foundation Catalog (for ordering materials); Are You Ready (pre-and interconceptional brochure for women); Are You Strong Enough (preconceptional and interconceptional brochure for men to complement the brochure for women); and Giving Our Children A Healthy Start (for the African American community).

Both the Healthy Beginnings and Baby Love Plus Programs continued to provide outreach, home visiting, care coordination, transportation, and other support services. The majority of the families remain African American and American Indian.

### c. Plan for the Coming Year

The First Step Campaign will continue to promote ways to improve the health of women of childbearing age and infants by the promotion of the NC Family Health Resource Line's information and referral service and First Step campaign activities focusing on African American and American Indian communities. The Back To Sleep Campaign will promote Sudden Infant Death Syndrome awareness and risk reduction practices targeting African American and Latino parents and childcare providers. In conjunction with the March of Dimes and N.C. Folic Acid Council, educational information and materials will be distributed that promote good health during women's childbearing years and raise awareness of consuming folic acid as a way to reduce birth defects. A focus will also include raising awareness of the dangers of smoking and secondhand smoke by promoting individual behavior change for pregnant teens, their families, and friends. Web-based information will continue to be updated to meet information needs of the public, health and human service providers, and the objectives of the educational campaigns. Assessments such as focus groups and consumer and outreach worker input will be used to develop information and appropriate format. Both Spanish and English versions of the following materials will be reprinted: Thanks For Asking; Back To Sleep Photonovella; Spanish Back To Sleep light switch cover; Humos Letales (Spanish language publication for young adults on secondhand smoke); Do Not Smoke decals featuring the message in multiple languages; Get Real ~ Secondhand Smoke Matters; Reality Check (encouraging pregnant teens to quit smoking); and Oh Baby (secondhand smoke). Also a Spanish language video and discussion guide entitled How Will I Pay For My Pregnancy? will be duplicated.

Two to three additional Targeted Infant Mortality Reduction Projects (TIMR) will be implemented to focus on improving the health of mothers, including entry into early prenatal care. Combined skillbuilding efforts will continue with representatives from NC's community based perinatal health network -- Healthy Beginnings, Baby Love Plus, Healthy Start Corps, and TIMR. These programs have community-driven, involvement components on MCH issues that reach local families.

## D. STATE PERFORMANCE MEASURES

State Performance Measure 1: *Number of children affected in substantiated reports of abuse and/or neglect as compared with previous years.*

Tracking Performance Measures
*[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]*

| Annual Objective and Performance Data | 2000 | 2001 | 2002 | 2003 | 2004 |
|---|---|---|---|---|---|
| Annual | | | | | |

| | | | | | |
|---|---|---|---|---|---|
| Performance Objective | | 30000 | 30000 | 30000 | 30000 |
| Annual Indicator | 31828 | 32581 | 32883 | 30016 | 27310 |
| Numerator | | | | | |
| Denominator | | | | | |
| Is the Data Provisional or Final? | | | | Final | Final |
| | **2005** | **2006** | **2007** | **2008** | **2009** |
| Annual Performance Objective | 27000 | 27000 | 26500 | 26500 | 26000 |

**Notes - 2002**

Manual indicator (count) is used in this state performance measure.

In the FY02 application, the annual indicators for FY97 through FY00 were revised from previous reports to include only unduplicated counts of substatiated cases instead of including duplicated counts when the same child is the subject of more than one investigative assessment during a given reporting period. Unduplicated counts are not available prior to FY97.

**Notes - 2003**

Manual indicator (count) is used in this state performance measure.

**Notes - 2004**

Manual indicator (count) is used in this state performance measure.

## a. Last Year's Accomplishments

Funding for 29 Adolescent Parenting Prevention projects was accomplished through an RFP process in FY04.

The Child Fatality Prevention Team Office received the Governor's Crime Commission (GCC) grant, on"Decriminalizing Infant Abandonment Training".

Prevent Child Abuse North Carolina (NCPEN), in collaboration with the NC Council for Women and Domestic Violence Commission, was given the responsibility of coordinating and monitoring the implementation of recommendations from the Legislative Child Well Being and Domestic Violence Task Force. The Public Health Alliance Against Violence Against Women was involved in implementation of one or more Task Force recommendations involving health agencies and expanded its focus to more comprehensively address child well being.

Through a grant from the GCC, the Children and Youth Branch contracted with Prevent Child Abuse NC (PCANC) to develop recommendations for the prevention of child maltreatment in children birth to age three. PCANC facilitated an interagency workgroup that included representatives from state and local agencies, medical providers, and university research specialists. A report on recommendations for implementation of activities to meet the Child Abuse Prevention Treatment Act (CAPTA) legislation was available by June 30, 2004. Parenting education activities and priorities for FY04 included: the second annual Parenting Education Institute in September 2003; continued collaboration with NCPEN; review, update and revision of program resources; and collaboration and advocacy for the inclusion of fathers/men in resources and services provided by the Women's and Children's Health Section (WCHS). On-going activities of the Fatherhood Project included: Fatherhood Development Curriculum training session in Pitt, Mecklenburg, and Guilford counties; development of a

speakers bureau; updating of a resource directory of male focused/fatherhood programs across NC; convening a Men 's Preventive Health Symposium (Men Are Nurturers, Too! Conference); educating policy makers to better represent the issues and concerns of the population; and conduct an assessment of the WCHS on father-friendly practices and services coordination.
The Specialized Services Unit worked with the Division of Social Services (DSS) in the implementation of the DSS Multiple Response System and with the Early Intervention Branch to develop a plan to implement the Child Abuse and Prevention Treatment Act. In addition, the Specialized Services Unit of the WCHS continued its work with the State Collaborative for Children's Mental Health in the development of the System of Care for young children with mental health issues. This included work with the Administrative Office of the Courts in the development of a five county initiative for the development of Family Drug Treatment Courts. The planning process involves assisting the court system to recognize health issues for children who have been victims of substantiated abuse/ neglect.

**Figure 4b, State Performance Measures from the Annual Report Year Summary Sheet**

| Activities | Pyramid Level of Service | | | |
|---|---|---|---|---|
| | DHC | ES | PBS | IB |
| 1. Continued implementation of the Adolescent Parenting Program projects. | | X | | |
| 2. Training of professionals and promotion of public awareness about the Infant Homicide Prevention Act | | | X | |
| 3. Assist with implementation of Child Well Being and Domestic Violence Task Force recommendations. | | | | X |
| 4. Continued collaboration with NC Parenting Education Network. | | | | X |
| 5. Continued support of the NC Fatherhood Development Advisory Council. | | | | X |
| 6. | | | | |
| 7. | | | | |
| 8. | | | | |
| 9. | | | | |
| 10. | | | | |

b. Current Activities

The Child Fatality Task Force (CFTF) Executive Director position was reinstated by the general assembly and discussions were conducted with the co-chairs of the Task Force about the efficacy of contracting the position for more flexibility or hiring within the state system. It was jointly determined that the position would remain in the Children and Youth Branch of the WCHS and it has recently been filled.
The CFPT Office did apply for a second year of funding for a statewide public awareness education campaign on Decriminalizing Infant Abandonment and materials have been developed through a multi-agency effort. A plan is in place for distribution of materials and publication of the program through various media campaigns.
Prevent Child Abuse North Carolina coordinates and monitors the implementation of recommendations from the legislative Child Well Being and Domestic Violence Task Force.
The Medical Consultant for the Children and Youth Branch participates in meetings and provides feedback to the Branch for appropriate integration and implementation initiatives.
NC Parent Education Network provides information on resources for parent educators through quarterly newsletters and web-based announcements. The third Parenting Institute was held during the year with statewide participation and strong positive evaluation feedback. As part of

our fatherhood initiative, we provided regional forums on inclusion, a statewide conference with more than four hundred participants, curriculum trainings and we maintained a leadership role in the Fatherhood Development Advisory Council.
The Branch has participated in training on the DSS Multiple Response System to improve knowledge and coordination of services for children who are abused or neglected. The Early Intervention Branch has initiated a roll out of activities to meet the new federal CAPTA requirements and have positive early results.
Work with the Administrative Office of the Courts in the development of a five county initiative related to planning for the development of Family Drug Treatment Courts is ongoing.

### c. Plan for the Coming Year

Posters, pamphlets and a media campaign will be conducted in the coming year to publicize Decriminalization of the Infant Abandonment Act. Outreach workers, home visitors and agencies such as local DSS, health departments and others will be targeted to receive this information in order to reach the population that is at risk for this behavior.

The Institute of Medicine's Task Force on Preventing Child Maltreatment has issued their final report and recommendations. In keeping with the recommendations, Children and Youth Branch applied for and received a grant to provide a series of trainings for Child Service Coordinators on how to effectively support families by promoting healthy parent-child interaction. This will be a four-day training spanning four months and will center solely on parent-child interaction and child development. Each month a new topic will be presented related to the importance of healthy parent-child interaction with special emphasis in preventing child abuse. The trainings will prepare coordinators to support and educate families on appropriate parent-child interaction practices in order to foster healthy child development.

The Children and Youth Branch hired a consultant in FY 05 to survey internal staff and programs in an effort to identify opportunities to increase our efforts in the prevention of child abuse. Recommendations by the consultant and by the Task Force will be considered in the context of Branch resources. Priorities will be established to enhance programs within the Branch that have the capacity to address risk and protective factors for child maltreatment including the Child Service Coordination Program, Family Support/Parenting Education, School Health, the Child Fatality Prevention Team and the Transition Program for at-risk adolescents.

A series of meeting dates has been established to begin discussions for improving communication with and training for the local child fatality prevention teams to enhance their capacity to provide viable and system-related recommendations to the State Child Fatality Team and state agencies that would impact the current practices and infrastructure to reduce the risks of mortality and morbidity for children in N.C.

State Performance Measure 4: *Percent of children less than 6 with elevated blood levels (greater than or equal to 10 micrograms/dL) of lead.*

Tracking Performance Measures
*[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]*

| Annual Objective and Performance Data | 2000 | 2001 | 2002 | 2003 | 2004 |
|---|---|---|---|---|---|
| Annual Performance | 0.8 | 0.8 | 0.8 | 0.8 | 0.8 |

| | | | | | |
|---|---|---|---|---|---|
| Objective | | | | | |
| Annual Indicator | 2.5 | 2.4 | 1.7 | 1.7 | 1.8 |
| Numerator | 2686 | 2781 | 2016 | 2116 | 2245 |
| Denominator | 105845 | 115856 | 119975 | 120966 | 121697 |
| Is the Data Provisional or Final? | | | | Final | Final |
| | **2005** | **2006** | **2007** | **2008** | **2009** |
| Annual Performance Objective | 0.8 | 0.8 | 0.8 | 0.8 | 0.8 |

**Notes - 2002**

FY year data are actually the prior calendar year, e.g. FY02 is really CY01.

**Notes - 2004**

FY year data are actually the prior calendar year, e.g. FY02 is really CY01.

## a. Last Year's Accomplishments

In CY04, there were 124,486 children ages six months to six years screened for elevated blood levels. Screenings by private medical providers, including community and rural health centers exceeded screenings conducted by local health departments, as local health departments screened 34,072 children and private clinics performed 90,414 screenings. These numbers remain high, chiefly due to the fact that the State Laboratory of Public Health has offered blood lead analysis at no charge since 1994. A targeted approach within local health departments continues. Children with the highest statistical risk for elevated blood lead levels, based on policies promoted by the CDC, are a major focus. Almost every child 12 and 24 months old attending local health department well child clinics was screened for blood lead. The screening rate for 1- to 2-year-olds receiving Medicaid was 55.9 %. There were 349 confirmed cases >=10 micrograms/dL and 52 confirmed cases >=20 micrograms/dL. Enhanced follow-up for children with screenings >=10 micrograms/dL continued as regional specialists working with children with elevated blood lead levels made a total of 259 investigative site visits. A public health nurse often teams with the regional specialist conducting the site visit.

**Figure 4b, State Performance Measures from the Annual Report Year Summary Sheet**

| Activities | Pyramid Level of Service | | | |
|---|---|---|---|---|
| | **DHC** | **ES** | **PBS** | **IB** |
| 1. Collaboration between WCHS and DEH/Children's Health Branch. | | | | **X** |
| 2. Ad-Hoc Lead Advisory Committee quarterly meetings. | | | | **X** |
| 3. Full-day clinical workshops for LHD staff and private healthcare providers conducted 3 times/year. | | | | **X** |
| 4. Annual 3-day Lead Investigation and Remediation workshop targeting local EH specialists. | | | | **X** |
| 5. New local EH specialists receive 1-day training. | | | | **X** |
| 6. Lead-Safe Work Practices workshops provided for housing renovators, housing agencies, and public. | | | **X** | |
| 7. GIS-based risk prioritization county maps created and revised. | | | | **X** |
| 8. Preventive Maintenance Program and education efforts to owners of | | | | **X** |

| | | | | |
|---|---|---|---|---|
| older residential rental property. | | | | |
| 9. State Laboratory of Public Health provides blood lead analysis at no charge. | | | X | |
| 10. Funds allocated to LHDs to provide medical and environmental follow-up of lead poisoned children. | | | | X |

b. Current Activities

To better serve the state's increasing Latino population, the Hispanic Task Force continues to meet on a quarterly basis. The state lead program supports initiatives designed to enhance outreach to the Latino population, including participation in El Flora Latin and LA Fiesta del Pueblo (annual events designed for outreach). A social marketing campaign designed for Latino families will be piloted in Wilson County in the spring. Legislative support for the introduction of the bill on tax incentives to eliminate or control lead hazards remains a priority. The North Carolina Childhood Lead Testing Manual is being updated, with plans for training and distribution to providers in the fall. Stakeholders are meeting to develop the childhood lead requirements for the NC DPH Electronic Disease Surveillance System.

c. Plan for the Coming Year

Continued collaboration and increased public awareness of the hazard of lead in children is expected with a special emphasis on the Latino population. Focused education for families of at-risk children will promote a decrease in overall numbers of cases of elevated blood lead levels. Implementation of North Carolina's plan to eliminate childhood lead poisoning by 2010 will continue. Duke University's Nicolas School of the Environment will continue toward the completion of a GIS-based lead risk model for 33 of North Carolina's 100 counties including the largest population centers and those counties at highest risk. This will foster the identification of houses at risk for lead hazards to children. Fifteen counties have completed the model. Activities will be implemented to enhance the participation of health care providers in the provision of blood lead screening and appropriate follow-up care, including training and distribution of the new North Carolina Childhood Lead Testing Manual.

State Performance Measure 5: *Percentage of women who gained > 15 pounds during pregnancy.*

Tracking Performance Measures
*[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]*

| Annual Objective and Performance Data | 2000 | 2001 | 2002 | 2003 | 2004 |
|---|---|---|---|---|---|
| Annual Performance Objective | 89 | 90 | 90.5 | 91 | 91.5 |
| Annual Indicator | 89.6 | 84.6 | 89.3 | 89.3 | 91.5 |
| Numerator | 101927 | 101735 | 105423 | 104742 | 108287 |
| Denominator | 113755 | 120247 | 118112 | 117307 | 118292 |
| Is the Data Provisional or Final? | | | | Final | Final |
| | **2005** | **2006** | **2007** | **2008** | **2009** |

| | | | | | |
|---|---|---|---|---|---|
| Annual Performance Objective | 92 | 92 | 93 | 93 | 93 |

**Notes - 2002**

FY year data are actually the prior calendar year, e.g. FY02 is really CY01.

**Notes - 2004**

FY year data are actually the prior calendar year, e.g. FY02 is really CY01.

## a. Last Year's Accomplishments

In CY03, 91.5% of women giving birth in NC gained >15 pounds during pregnancy. This is a slight increase from the past few years where the percentage hovered around 89%.

The Baby Love Program, specifically through the Maternity Care Coordinators (MCCs) and Maternal Outreach Workers (MOWs), provides case management and support services to pregnant women. These services are also designed to support women and provide education on the importance of adequate weight gain during pregnancy. The MOWs and MCCs provide care coordination which includes ensuring the pregnant women have access to WIC services. They also work with women to ensure they have nutritious food available in the home.

The Perinatal Outreach and Education Training (POET) Program has focused on several primary areas of emphasis, including perinatal HIV; substance abuse (includes smoking); health disparities; breastfeeding; preconceptional and interconceptional health; stress, anxiety and depression; and the promotion of best practices in perinatal care. This is inclusive of programs on appropriate weight gain.

**Figure 4b, State Performance Measures from the Annual Report Year Summary Sheet**

| Activities | Pyramid Level of Service | | | |
|---|---|---|---|---|
| | DHC | ES | PBS | IB |
| 1. Maternal Care Coordination and Maternal Outreach Worker Programs. | | X | | |
| 2. Intensive Medical Nutrition Therapy counseling available at LHDs. | X | | | |
| 3. Interpreter and bilingual services in LHDs to assure access to immigrants. | | X | | |
| 4. School-based and school-linked clinics educate on disordered eating in youth. | | | X | |
| 5. | | | | |
| 6. | | | | |
| 7. | | | | |
| 8. | | | | |
| 9. | | | | |
| 10. | | | | |

## b. Current Activities

The new Women's Health Nutrition Consultant staff person was hired at the beginning of the fiscal year. The new staff person was immersed in orientation during the majority of the fiscal year. Basic activities included monitoring local health departments and high-risk maternity clinics to determine that appropriate interventions were being provided for pregnant women. This orientation phase has allowed the new staff person the opportunity to assess local provider needs as it relates to women's health and nutrition. The "Healthy Mom, Healthy Baby"

educational booklet continues to be distributed by local maternal health providers. This includes information on nutrition and pregnancy.

### c. Plan for the Coming Year

During the coming year, the Women's Health Nutrition Consultant will provide guidance and technical assistance on women's health and nutrition, with a focus on appropriate weight gain during pregnancy. This position will focus on best practice efforts and provider training on nutrition issues. This position will also be instrumental in working with the nutritionists at High Risk Maternity Clinics, local health department staff, and outreach workers with community based organizations in the provision of education and support surrounding appropriate weight gain for pregnant women. The implementation of a new project to train health care providers to assess and address weight issues (low weight gain and excessive weight) for women of childbearing age will further expand the focus on inappropriate weight status as a health risk for mother and child.

State Performance Measure 6: *Percent of children 5-18 who are obese. Obesity is conservatively defined as a body mass index (BMI) greater than or equal to the 95th percentile for gender and age.*

Tracking Performance Measures
*[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]*

| Annual Objective and Performance Data | 2000 | 2001 | 2002 | 2003 | 2004 |
|---|---|---|---|---|---|
| Annual Performance Objective | 15 | 15 | 15 | 15 | 15 |
| Annual Indicator | 19.2 | 22.4 | 22.2 | 23.0 | 24.1 |
| Numerator | 4171 | 5362 | 5234 | 5219 | 5057 |
| Denominator | 21773 | 23890 | 23622 | 22688 | 20946 |
| Is the Data Provisional or Final? | | | | Final | Final |
| | **2005** | **2006** | **2007** | **2008** | **2009** |
| Annual Performance Objective | 15 | 15 | 15 | 15 | 15 |

**Notes - 2002**

FY year data are actually the prior calendar year, e.g. FY02 is really CY01.

**Notes - 2003**

North Carolina-Nutrition and Physical Activity Surveillance System (NC-NPASS) includes data on children seen in North Carolina Public Health Sponsored WIC and Child Health Clinics and some School Based Health Centers.

**Notes - 2004**

North Carolina-Nutrition and Physical Activity Surveillance System (NC-NPASS) includes data on children seen in North Carolina Public Health Sponsored WIC and Child Health Clinics and

some School Based Health Centers.

FY year data are actually the prior calendar year, e.g. FY02 is really CY01.

## a. Last Year's Accomplishments

Unfortunately, obesity in children age 5 to 18 in NC continues to increase. Data from the NC Nutrition and Physical Activity Surveillance System (NC-NPASS) which is comprised of data collected on children seen in NC Public Health sponsored Women, Infants and Children (WIC) and child health clinics and some school-based health centers, show that the percentage of children age 5 to 18 who were obese (Body Mass Index >=95th percentile) has steadily increased from 19.9% in 1999 to 24.1% in 2003.

In FY04, many activities were undertaken related to childhood overweight, including funding opportunities, surveillance system improvements, and new interventions. Local communities were awarded $220,887 by DPH to implement recommendations from "Moving Our Children Toward a Healthy Weight - Finding the Will and the Way" and the "Blueprints for Changing Policies and Environments in Support of Healthy Eating and Increased Physical Activity." In addition, the Health and Wellness Trust Fund Commission, chaired by the Lieutenant Governor, released an RFA based on the HWI recommendations. Grants in amounts of $75,000 to $150,000 for each of three years were awarded to 12 community organizations and 4 regional/statewide organizations. The focus of these grants is obesity prevention in children and people who influence them. The NC-NPASS is in the process of being enhanced to monitor trends in key nutrition and physical activity behaviors, with computer programming for the HSIS system completed in June 2004. An ongoing project for a stand alone Microsoft Access version of the database is still in development. The Nutrition and Physical Activity Self-Assessment for Child Care intervention was implemented in six counties throughout the state, with two additional counties serving as controls. Twelve intervention centers and four control centers participated in this pilot intervention. The model for this intervention includes use of a local health professional, the Child Care Health Consultant, who is typically a registered nurse, to provide individual guidance, continuing education and targeted technical assistance to the child care centers in that county.

**Figure 4b, State Performance Measures from the Annual Report Year Summary Sheet**

| Activities | Pyramid Level of Service | | | |
|---|---|---|---|---|
| | DHC | ES | PBS | IB |
| 1. Continuation and expansion of Nutrition and Physical Activity Self Assessment for Child Care. | | | | X |
| 2. Enhancement of Nutrition and Physical Activity Surveillance System. | | | | X |
| 3. Local funding provided for community-based interventions on healthy eating and physical activity. | | X | | |
| 4. Healthy Weight Initiative (CDC grant funded project) activities continue. | | | | X |
| 5. | | | | |
| 6. | | | | |
| 7. | | | | |
| 8. | | | | |
| 9. | | | | |
| 10. | | | | |

## b. Current Activities

Major outcomes related to obesity prevention in school age children have occurred this year due to collaborative efforts with the NC Department of Public Instruction (DPI). These outcomes have built on the State Board of Education's (SBOE) response to the report of the C & Y Branch's Healthy Weight Initiative, "Moving Our Children Toward a Healthy Weight."

In FY05, the SBOE changed one of its 5 strategic priorities to include health. Strategic Priority #2 now reads: "Focus on Healthy Students in Safe, Orderly and Caring Schools.
Among the results that have been accomplished are:
-Revision of the Healthy Active Children Policy to require at least 30 minutes of daily physical activity in grades K-8 by the 2006-07 school year.
-Implementation of pilots for the Eat Smart School Standards in elementary schools in 7 school districts.
-Support for 145 school nurse positions provided to local schools through the DPH
-Adoption of an anti-harassment, anti-bullying and anti-discrimination policy that includes obesity as one of the target areas.

In addition, the C&Y Branch has begun integrating obesity prevention in all existing programs when feasible. Among the strategies are the following:
1. Build capacity of the School Health Unit to integrate obesity prevention in existing programs.
- Nutrition program consultant position created and filled.
-Physical activity program consultant position approved and budget reallocation requested.
2. Build school nurse capacity in LEAs that do not currently meet the 1:750 recommended school nurse to student ratio, to allow increased school nurse involvement in obesity prevention.
3. Add a required nutrition performance measure to School Health Center contracts and agreement addenda for the tracking of BMI on growth charts and a minimum of two counseling sessions for students with BMI > 95th percentile.
4. Collaborate with PAN Branch, Nutrition Services Branch, DPI and Cooperative Extension on Eat Smart Move More grant objectives.
5. Collaborate in work on the NC Health and Wellness Trust Fund Commission grant to DPH on effective strategies for obesity prevention in minority elementary school students.
6. Assist with pilots of a nationally developed staff wellness program in two LEAs. Obesity prevention is one part of that wellness program.
7. Enhance capacity of SSU to provide obesity prevention and treatment services for children meeting program's parameters.
8. Integrate obesity prevention into all C & Y programs when appropriate.

### c. Plan for the Coming Year

During FY06, the C&Y Branch will continue to work on the activities detailed in the previous section. Surveillance through the NC-NPASS system will continue. In addition, obesity prevention will be integrated in local action plans for school nurses. Plans are being made to develop and provide training on obesity prevention to school nurses in FY06, including a presentation by the Nutrition Program Consultant at the state school nurse conference "To BMI or not to BMI". Technical assistance and training on obesity prevention and treatment will also be provided to School Health Center staff in FY06.

## State Performance Measure 8: *Percent of adolescents in public schools with access to services of a school-based or school-linked health care center.*

| Tracking Performance Measures<br>*[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]* | | | | | |
|---|---|---|---|---|---|
| **Annual** | | | | | |

| Objective and Performance Data | 2000 | 2001 | 2002 | 2003 | 2004 |
|---|---|---|---|---|---|
| Annual Performance Objective | 2.9 | 9 | 9 | 10 | 10 |
| Annual Indicator | 9.4 | 9.7 | 9.6 | 6.8 | 5.4 |
| Numerator | 60607 | 63972 | 63371 | 47569 | 39082 |
| Denominator | 642172 | 660055 | 662000 | 699436 | 723416 |
| Is the Data Provisional or Final? | | | | Final | Final |
| | **2005** | **2006** | **2007** | **2008** | **2009** |
| Annual Performance Objective | 10 | 10 | 10 | 10 | 10 |

**Notes - 2002**

Data are for School Year, eg. 2002 is August 2001 to May/June 2002.

For FY00 data and beyond, the definition of this indicator has been changed from including children (age 5 to 9) to including only adolescents aged 10 to 19.

**Notes - 2004**

Data are for School Year, eg. 2002 is August 2001 to May/June 2002.

For FY00 data and beyond, the definition of this indicator has been changed from including children (age 5 to 9) to including only adolescents aged 10 to 19.

## a. Last Year's Accomplishments

Providing credentialing reviews, strengthening continuous quality improvement (CQI), and moving toward the Department's new performance based contract system have been the highlights of work this year.

Six credentialing reviews were made in FY04 to school-based/school-linked (SB/SL) health centers first credentialed in 2001, and ten credentialing reviews were made to centers requesting first-time credentialing. One of the previously credentialed centers and one of the first time centers did not meet the credentialing standards and indicated they expected to be prepared for a second review in August/September 2004. Other centers either met the standards in the site review or were close enough to write 3-month corrective action plans. To date, eight of these ten centers have been credentialed and two are still completing corrective action plans. Reviews were done in one-day visits by a team of 4 reviewers. Most reviewers were DPH staff, however, some assistance was provided by peer reviewers from centers with best practice in the areas they reviewed. Two follow-up team meetings have been held to identify and incorporate enhancements to the credentialing system and refine the existing monitoring process.

CQI was an important component of the credentialing process, and center staff received valuable technical assistance in this area during the reviews. Because staff turnover is high in NC SB/SL health centers, it is likely that training and technical assistance will need to be ongoing to ensure than centers are implementing CQI fully in a way that ensures its effectiveness. Annual visits by Regional School Nurse Consultants provided technical assistance to all SB/SL health centers that did not have a credentialing review this year. The

Finance Technical Assistance Team continued to provide financial practice assessment site visits and training to center staff.

**Figure 4b, State Performance Measures from the Annual Report Year Summary Sheet**

| Activities | Pyramid Level of Service | | | |
|---|---|---|---|---|
| | DHC | ES | PBS | IB |
| 1. Regional and Management technical assistance to projects. | | | | X |
| 2. Financial Practice Assessment site visits. | | | | X |
| 3. Credentialing of SB/SLHCs. | | | | X |
| 4. Establishing benchmark standards for SB/SLHCs related to productivity, charges and receipts. | | | | X |
| 5. Data collection and analysis. | | | | X |
| 6. RFAs for the planning and development of new SB/SLHCs. | | | | X |
| 7. Collaboration between the State and local projects. | | | | X |
| 8. Development of the Outcomes Initiative (Continuous Quality Improvement System) | | | | X |
| 9. | | | | |
| 10. | | | | |

b. Current Activities

The two centers that had corrective action plans in FY04 completed them successfully in FY05 and were credentialed, bringing to 23 the number of Credentialed Comprehensive Health Centers in the State. RFAs were issued for funding to two categories of centers, Credentialed Comprehensive Health Centers and Alternate Model Health Centers. The Alternate Model Health Centers are not required to provide comprehensive services, but must provide one or more of the four service areas required for Comprehensive Health Centers. Awards were made to 15 sponsors for 28 School Health Centers for SY06. All 23 Credentialed Comprehensive Health Centers were funded and five Alternate Model Health Centers were funded. The awards will be renewable for SY07 and SY08 pending contractor performance and availability of funds. State funding for school health centers has been flat for the past decade and was inadequate to meet all requests.

Findings in the credentialing reviews and financial practice assessment site visits during FY04 provided the foundation for training that was developed and implemented in FY05. Two trainings, held in different areas of the state, were provided by the School Health Center Management Team, assisted by Center staff with special success in meeting performance measurers. All but one center were represented in the training by one or more staff members. A technical assistance visit was made to that school to provide training. Technical assistance this year includes annual visits to all centers by the Clinical Services Coordinator, supplemented by visits from the mental health consultant and two Child Health Nurses. Additional TA is provided by telephone, participation in regional meetings of the School Health Center Association, and participation in the School Health Center Advisory Committee. The Finance Technical Assistance Team is providing support to all centers, through site visits or telephone consultation, depending on the needs of the site.

The purpose of the site and/or telephone consultation is two-fold: 1) to support the further development of a CQI self-assessment process linked to performance measures and quality standards, and 2) to increase accountability and consistency in performance measurement.

A temporary business liaison specialist did a review of data needs of the School Health Center Program. Recruiting is underway for a social research associate. This position will implement recommendations, provide training and technical assistance to Center staff, and showcase success in the centers.

### c. Plan for the Coming Year

The NC Credentialing process provides for re-credentialing every three years. Five Centers are scheduled for re-credentialing reviews next year and three Alternate Model Health Centers that have indicated interest in becoming Credentialed Comprehensive Health Centers and will receive reviews. This process will be a one-day review by a 4-member team.

Centers that are not scheduled for credentialing reviews in FY 06 will have a site visit by the Clinical Services Coordinator and other team members if needed. Technical assistance by the School Health Center Management Team will again focus on the Centers' Continuous Quality Improvement Plans as well as financial management practice issues. Data training sessions will also be held (probably regionally), and visits by the data manager are planned for all sponsors.

One School Health Center closed at the beginning of FY05. School enrollment rose in most schools; however, state funding did not increase and some Centers lost external foundation funding and were unable to increase services. State funding for school health centers has been flat for the past decade. RFA requests far exceeded available funds, so most centers were funded at lower levels than requested, and two proposals for Alternate Model Centers were not funded. Several of the centers have received state and national attention this year for outstanding programs and that has created interest by child advocacy groups in additional funding. Obesity prevention and mental health are the two issues receiving the most attention. A bill to study School Health Center costs and benefits was introduced April 13, 2005.

The General Assembly established the School Nurse Funding Initiative in July 2001 and provided 145 school nurses in schools systems with high financial and health needs. This required extensive work by the Regional School Nurse Consultants and their role in providing technical assistance for school health centers was greatly diminished. However, two Child Health Nurses in the Best Practice Unit were made available and have proved to be excellent additions to the School Health Center Management Team. These nurses will continue is this role in FY06.

The School Health Center Advisory Committee has been expanded to include a representative from all Centers. The committee continues to be an important mechanism for sharing information, discussing issues and fostering collaboration.

## State Performance Measure 9: *The percent of women who smoke during pregnancy.*

Tracking Performance Measures
*[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]*

| Annual Objective and Performance Data | 2000 | 2001 | 2002 | 2003 | 2004 |
|---|---|---|---|---|---|
| Annual Performance | 14.0 | 14 | 13.5 | 13 | 13 |

| | | | | | |
|---|---|---|---|---|---|
| Objective | | | | | |
| Annual Indicator | 14.3 | 14.0 | 14.0 | 13.2 | 12.7 |
| Numerator | 16225 | 16786 | 16479 | 15440 | 14995 |
| Denominator | 113755 | 120247 | 118112 | 117307 | 118292 |
| Is the Data Provisional or Final? | | | | Final | Final |
| | **2005** | **2006** | **2007** | **2008** | **2009** |
| Annual Performance Objective | 12 | 12 | 12 | 11 | 10 |

**Notes - 2002**

FY year data are actually the prior calendar year, e.g. FY02 is really CY01.

**Notes - 2004**

FY year data are actually the prior calendar year, e.g. FY02 is really CY01.

## a. Last Year's Accomplishments

The percent of women with live births in NC who smoked during pregnancy according to birth certificate data continues to decline slowly. In 2003, 12.7% of women reported to smoke during pregnancy as compared to 14.2% in 2000.

The Women's Health and Tobacco Use (WHTU) Program Consultant continued to manage the Women's program's activities. The WHB received second year funding from the Health and Wellness Trust Fund Commission of NC to implement the Smoking Cessation for Pregnant Teens Project (SCPTP). Three Carolina ACCESS (Medicaid) sites in NC (Durham County Health Department, Gaston County Health Department, and Robeson Health Care Corporation) developed policies and procedures to integrate smoking cessation counseling into prenatal care services. These office-based systems continued to be piloted in the three sites in order to develop lessons learned from the process. Under the SCPTP, the WHB continued to provide funding to the NCHSF to develop, print and distribute new age-appropriate smoking cessation and secondhand smoke educational materials. The development and design for the smoking cessation educational material for pregnant teens was completed.

The WHB continues to collaborate with ACOG in the Provider Partnership Project on women and tobacco. A subcommittee of the Women and Tobacco Coalition for Health (WATCH), the Survey Action Team, developed the NC Collaborative Survey on Smoking Cessation During Pregnancy to assess clinical practice behaviors and resource and training needs among all prenatal care providers in the state. This survey was pilot tested, printed, and distributed through ACOG.

**Figure 4b, State Performance Measures from the Annual Report Year Summary Sheet**

| Activities | Pyramid Level of Service | | | |
|---|---|---|---|---|
| | **DHC** | **ES** | **PBS** | **IB** |
| 1. Distribute the revised Guide for Counseling Women Who Smoke and other educational materials. | | | **X** | |
| 2. Develop and implement the Smoking Cessation for Pregnant Teens Project. | | | | **X** |
| 3. Facilitate and manage the Women and Tobacco Coalition for Health | | | | |

| | | | | |
|---|---|---|---|---|
| activities. | | | | X |
| 4. Develop/sustain partnerships with women's health and tobacco use prevention/cessation organizations. | | | | X |
| 5. | | | | |
| 6. | | | | |
| 7. | | | | |
| 8. | | | | |
| 9. | | | | |
| 10. | | | | |

b. Current Activities

During FY05, the Program Consultant position has been vacant the majority of the fiscal year. Plans are underway to re-fill the position with an April timeline. In the interim, the Guide for Counseling Women Who Smoke was distributed to over 100 health care and human service providers across NC, as well as to other states in the nation. The Guide distribution is coupled with training by the Perinatal and Neonatal Outreach and Education Trainers (POETs/NOETs) across the state.

Under the SCPTP, counseling services for smoking cessation and secondhand smoke are being provided at all three project sites. There continues to be quarterly Program Coordinator meetings and site visits at each project site. The new secondhand smoke educational material for pregnant teens was completed and distributed, with primary focus being in project area counties.

The NC Collaborative Survey on Smoking Cessation During Pregnancy was distributed to over 1,600 prenatal care providers with a response rate of over 60%. A report of the final survey findings is being developed and printed by May 2005. This report will be distributed to survey respondents, health care and human service providers, and other interested parties. Data collected from this survey will be used to determine future WATCH initiatives.

c. Plan for the Coming Year

During FY06, the new Program Consultant will continue to facilitate and manage WATCH activities and quarterly meetings. New action teams will be developed to lead specific WATCH activities based upon survey findings. Existing partnerships will be strengthened and new partnerships will form to support WATCH initiatives. The Program Consultant will continue to manage and support the SCPTP while developing lessons learned that can be shared statewide.

As part of the state's efforts to reduce smoking among pregnant women, all local health department prenatal care providers will be required to counsel women who smoke utilizing the 5A best practice method -- ask, advise, assess, assist, and arrange. The Perinatal and Neonatal Outreach Education Trainers (POETs/NOETs) will provide leadership in training local staff. The POETs/NOETs are highly trained and skilled nurse educators affiliated with universities, medical schools, and area health education centers (AHECs) in the state.

State Performance Measure 11: *The percent of women responding to the Pregnancy Risk Assessment Monitoring System (PRAMS) survey that they wanted to be pregnant later or not then or at any time in the future.*

Tracking Performance Measures
*[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]*

| Annual Objective and Performance Data | 2000 | 2001 | 2002 | 2003 | 2004 |
|---|---|---|---|---|---|
| Annual Performance Objective | | 40 | 40 | 40 | 40 |
| Annual Indicator | 41.9 | 45.3 | 42.6 | 40.6 | 42.2 |
| Numerator | | | | | |
| Denominator | | | | | |
| Is the Data Provisional or Final? | | | | Final | Final |
| | **2005** | **2006** | **2007** | **2008** | **2009** |
| Annual Performance Objective | 40 | 39 | 39 | 38 | 38 |

**Notes - 2002**

These data are taken from weighted responses to the Pregnancy Risk Assessment Monitoring System and are based on previous calendar year data. Release of weighted data for CY01 (FY02) has been delayed and has not yet been released by the Centers for Disease Control and Prevention. Once they release the data, this measure can be updated.

**Notes - 2003**

FY01 data (actually CY00 survey data) was replaced with weighted data in spring 2004. FY03 data have not yet been released from the CDC.

**Notes - 2004**

PRAMS data are weighted to get the final state percentage, so numerator and denominator data are not available.

## a. Last Year's Accomplishments

The unintended pregnancy rate for North Carolina, as measured in PRAMS, has been steadily declining. The combined rates for the 1997-99 cycle was 45.1%. The most current PRAMS data from CY02 show that 40.6% of pregnancies were unintended. This is a slight decrease from the weighted percentage from CY01 (42.6%). More significantly, while the current rate is lower than the 2010 objective (43%) in the Logic Model adopted by the Women's Health Branch, it is much higher than the national HP2010 objective of 30%. The Logic Model intermediate objective will be revised to concur with the HP2010 objective. A related objective, also included in the Logic Model, is to increase the proportion of women (and their partners) enrolled in the statewide Family Planning Program who use an effective, long-term contraceptive method from 84% in CY02 to 100% in 2010. In CY04, 81.8% of the women enrolled in the program were using long-term contraceptives. Emergency contraception, foam and condoms, and abstinence were excluded from this total.

A number of factors may have contributed to the declining trend in unintended pregnancies. The FPRHU continues to provide comprehensive family planning services through a network of approximately 140 service sites throughout the state which served 138,270 unduplicated patients in CY04. The number of patients served in CY04 decreased by approximately 3.3% compared to CY03. The decline in patient numbers has been attributed to underreporting of patients from a large, urban health department. However, the long-term trend projects positive

growth in patients served in spite of severe budget cuts and significant increases in the cost of contraceptives and other supplies (Thin Prep) the past two years. Local outreach initiatives to improve access to services, reduce unintended pregnancies, and increase patient numbers began in FY99 with special initiative funds and has continued through FY03. The growth momentum resulting from these initiatives is expected to sustain the long-term trend. The success of the demonstration projects enabled the FPRHU to formally adopt a performance based funding strategy in distributing additional funds in FY04, which awarded local health departments "bonus" funds commensurate with long term and short term patient increases.

In conjunction with the Division-wide accountability initiative, the FPRHU participated in the continuing development of logic models that address improvements in the health of women of childbearing age and reductions in infant mortality. Towards this end, the FPRHU has adopted intermediate outcomes that specifically address reductions in unintended pregnancies, teen births, and the percent of live births with short birth intervals, and increasing the proportion of females at risk of unintended pregnancies that are using the most effective contraceptive methods, as noted above.

**Figure 4b, State Performance Measures from the Annual Report Year Summary Sheet**

| Activities | Pyramid Level of Service | | | |
|---|---|---|---|---|
| | DHC | ES | PBS | IB |
| 1. Full implementation of the 1115(a) demonstration waiver (Medicaid waiver). | | | | X |
| 2. Continuation and expansion of the Hispanic/Latino Outreach Initiatives. | | X | | |
| 3. Continuation and expansion of special outreach initiatives, particularly to teen patients. | | X | | |
| 4. Continuation of sterilization funding and services. | | | | X |
| 5. Continuation of TPPI, with greater emphasis on programs for Hispanic/Latino youth. | | | | X |
| 6. | | | | |
| 7. | | | | |
| 8. | | | | |
| 9. | | | | |
| 10. | | | | |

## b. Current Activities

In cooperation with staff from the NC DMA, the FPRHU is currently in the initial phase in the implementation of the recently approved 1115(a) Medicaid Demonstration Waiver. The Medicaid waiver will extend eligibility for family planning services to all women and men over age 18 with incomes at or below 185% of the federal poverty level regardless of receipt of previous Medicaid reimbursed service (pregnancy-related or otherwise). The major goal of the waiver is to reduce unintended pregnancies and improve the well being of children and families in NC. Among several objectives, two specifically target reductions in the number of inadequately spaced pregnancies and in the number of unintended and unwanted pregnancies among women eligible for Medicaid. A social marketing plan, in its final phase of development, will be implemented in FY05. The target audience is men and women eligible for the waiver.

The significant increase in the Hispanic/Latino population of the state continues to be a challenge for local maternal health and family planning clinics. To help meet this challenge, the

FPRHU is continuing to fund and expand the Latino Family Planning Outreach Initiative with $300,000 in special Title X funds and to support special Latino APP programs. A Request for Application has recently been reissued to local public and private not-for-profit agencies located in communities with high Hispanic/Latino population growth rates. The FPRHU is also currently implementing the specific action steps prescribed for the unit in DPH's Recommendations for Eliminating Health Disparities.

The FPRHU is continuing to develop an internal capacity to apply social marketing principles to its programs, as well as provide consultation and technical assistance to local delegate agencies wishing to use this approach. These efforts are intended to further the goals of the program to prevent unintended pregnancies by enhancing the ability of local providers to recruit clients and provide outreach and education to the communities they serve.

Funding for sterilization services, temporarily suspended in FY03, has been restored in FY05 at approximately $540,000.

A recent reorganization of the Women's Health Regional Nurse Consultants (RNCs) facilitates the continuing implementation of the aforementioned divisionwide accountability system. In addition, the new structure is designed to improve and streamline the provision of technical assistance and consultation to local grantee agencies related to the Medicaid waiver and other family planning issues that impact on efficiency and cost effectiveness of clinical services. RNCs are working closely with the four regional Women's Health Social Work Consultants (RSWCs) to conduct systematic assessment of local agencies success in meeting specific process and outcome objectives related to reductions in unintended pregnancies.

### c. Plan for the Coming Year

The FPRHU will continue the initial implementation of the recently approved 1115(a) Medicaid demonstration waiver. Full implementation of the Medicaid waiver may take the remainder of this year and most of next year. Data from the social marketing contract will be carefully analyzed by Unit staff and the contract agency, and results will help shape future social marketing activities for the Medicaid waiver. RNC reorganization will continue to be refined, and activities and responsibilities added as the waiver is implemented. Accountability issues will also be a major focus particularly as they relate to local contracts, which now must reflect specific intermediate outcomes in the logic models. The emphasis on increasing patient census, particularly teens, will continue. The TPPI will continue to expand with the restoration of TANF funds. This is significant in light of the high rates of out-of-wedlock births and unintended pregnancies among teens.

State Performance Measure 12: *Percent of women of childbearing age taking folic acid regularly.*

Tracking Performance Measures
*[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]*

| Annual Objective and Performance Data | 2000 | 2001 | 2002 | 2003 | 2004 |
|---|---|---|---|---|---|
| Annual Performance Objective | | | 50 | 50 | 50 |
| Annual Indicator | 46.9 | 49 | 42.2 | 42.2 | 47.1 |

| | | | | | |
|---|---|---|---|---|---|
| Numerator | | | | | |
| Denominator | | | | | |
| Is the Data Provisional or Final? | | | | Provisional | Final |
| | **2005** | **2006** | **2007** | **2008** | **2009** |
| Annual Performance Objective | 50 | 50 | 50 | 50 | 50 |

**Notes - 2002**

Data source is he Behavioral Risk Factor Surveillance System. Unweighted numerator and denominator are not available. Data are based on prior calendar year, e.g., FY02 is really CY01 data.

**Notes - 2003**

2003 data are not available as the folic acid module was not included in the state's BRFSS for this year. As an estimate has to be entered into the data system, the CY02 data value was entered, but there is no way to know if this is a good estimate or not.

**Notes - 2004**

Data source is he Behavioral Risk Factor Surveillance System. Unweighted numerator and denominator are not available. Data are based on prior calendar year, e.g., FY02 is really CY01 data.

## a. Last Year's Accomplishments

In collaboration with other partners, in FY04 the NC Folic Acid Council completed a structured strategic planning process, strengthened infrastructure, created and adopted a new Governance Agreement, and increased membership capacity. An Eastern Folic Acid Campaign Coordinator was hired to complement the Western Folic Acid Campaign Coordinator. In addition to infrastructure and planning, there was an increased focus on education for young women aged 18-24. Activities included social marketing and consumer testing of folic acid and multivitamin promoting messages (to form the basis of future marketing work). The Community Ambassador (consumer peer education) program reached consumers through health and bridal fairs and other community events. Education and incentive items were distributed to public health, medical, and educational institutions across the state. Radio media campaigns targeted Latino communities in the west, the Charlotte area, and the eastern region. The Office Champion (health provider education) program continued to expand in the western region, and the program materials were standardized for statewide use.

**Figure 4b, State Performance Measures from the Annual Report Year Summary Sheet**

| **Activities** | **Pyramid Level of Service** | | | |
|---|---|---|---|---|
| | **DHC** | **ES** | **PBS** | **IB** |
| 1. Education of health care professionals via a variety of strategies | | | | **X** |
| 2. Education of consumers and reminders to take a multivitamin daily | | | **X** | |
| 3. Mass media and public awareness activities | | | **X** | |
| 4. | | | | |
| 5. | | | | |
| 6. | | | | |
| 7. | | | | |

| | | | | |
|---|---|---|---|---|
| 8. | | | | |
| 9. | | | | |
| 10. | | | | |

b. Current Activities

State funding of $300,000 continues to support and expand activities from previous years in FY05. Current emphasis is on improving/enhancing the market message to break through the 35- 40% level of multivitamin intake and will focus tightly on messages and behavior change for women 18-24 years. Activities include: redesigning the web site (www.getfolic.com), developing new campaign materials (e.g. posters, PSAs and brochures are being designed and promoted by an advertising agency), building the infrastructure and capacity for the Eastern Region Campaign, continuing support of the Fullerton Genetics Center's Western Region Campaign, expanding and evaluating the Office Champion program, and continuing distribution of campaign materials through the NCHSF and the NC Family Health Resource Line.

Much of the planning efforts are directed at the $3 million settlement from a multi-state vitamin anti-trust lawsuit. These funds have been allocated to the Folic Acid Council's fiscal agent, the NC March of Dimes, and will be available through 2009.

c. Plan for the Coming Year

Efforts and activities to expand and support the NC Folic Acid Council infrastructure as well as targeted interventions to affect awareness and behavior change are planned for FY06. Objectives include maintaining committee participation, training new community volunteers, continuing funding for statewide and regional campaign coordinators, distributing new campaign materials, and broadening population reach by hiring an additional regional coordinator and a Hispanic Outreach Coordinator.

State Performance Measure 13: *The ratio of school health nurses to the public school student population.*

Tracking Performance Measures
*[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]*

| **Annual Objective and Performance Data** | **2000** | **2001** | **2002** | **2003** | **2004** |
|---|---|---|---|---|---|
| Annual Performance Objective | | 1:2100 | 1:2000 | 1:1900 | 1:1700 |
| Annual Indicator | 1:2198 | 1:2075 | 2,047.0 | 1,918.1 | 1,897.2 |
| Numerator | | | 1271995 | 1279768 | 1311163 |
| Denominator | | | 621.4 | 667.2 | 691.1 |
| Is the Data Provisional or Final? | | | | Final | Final |
| | **2005** | **2006** | **2007** | **2008** | **2009** |
| Annual Performance | 1:1500 | 1300 | 1200 | 1200 | 1150 |

| Objective | | | | | |
|---|---|---|---|---|---|

**Notes - 2002**

As ratios are not allowed in state performance measures at this point, the actual indicator is not going to be very meaningful for this measure, but one needs to look at the numerator (number of public school students in NC) and denominator (number of er school health nurse FTEs) to get the 1:XXX ratio. The goal is to have one nurse per 750 students, but NC is still a long way from accomplishing that goal at 1:2047.

The indicators for 2006 and 2007 just list the number of students per school health nurse as a ratio isn't allowed.

School health nurse to student ratios were based upon full-time equivalencies of school nurse staff. The number of students and school health nurse FTEs from which the ratios were calculated are as follows:

FY97 Students: 1,183,335 School Nurse FTEs: 425.50
FY98 Students: 1,206,607 School Nurse FTEs: 465.10
FY99 Students: 1,218,135 School Nurse FTEs: 491.25
FY00 Students: 1,237,794 School Nurse FTEs: 563.15
FY01 Students: 1,243,442 School Nurse FTEs: 599.22

**Notes - 2003**

As ratios are not allowed in state performance measures at this point, the actual indicator is not going to be very meaningful for this measure, but one needs to look at the numerator (number of public school students in NC) and denominator (number of er school health nurse FTEs) to get the 1:XXX ratio. The goal is to have one nurse per 750 students, but NC is still a long way from accomplishing that goal at 1:1918.

The indicators for 2006, 2007, and 2008 just list the number of students per school health nurse as a ratio isn't allowed.

**Notes - 2004**

As ratios are not allowed in state performance measures at this point, the actual indicator is not going to be very meaningful for this measure, but one needs to look at the numerator (number of public school students in NC) and denominator (number of er school health nurse FTEs) to get the 1:XXX ratio. The goal is to have one nurse per 750 students, but NC is still a long way from accomplishing that goal at 1:1897.

The indicators for 2006 to 2008 just list the number of students per school health nurse as a ratio isn't allowed.

School health nurse to student ratios were based upon full-time equivalencies of school nurse staff. The number of students and school health nurse FTEs from which the ratios were calculated are as follows:

FY97 Students: 1,183,335 School Nurse FTEs: 425.50
FY98 Students: 1,206,607 School Nurse FTEs: 465.10
FY99 Students: 1,218,135 School Nurse FTEs: 491.25
FY00 Students: 1,237,794 School Nurse FTEs: 563.15
FY01 Students: 1,243,442 School Nurse FTEs: 599.22

## a. Last Year's Accomplishments

The six regional school nurse consultants continued to work within their regions to promote the development and expansion of school health services. An RFA entitled "Healthy Students Ready to Learn" to fund 40 new school nurse positions and a special Coordinated School

Health Program component was developed and distributed to local communities. Eighty-two applications were received, reviewed and ranked for funding to begin in FY05. The State Board of Education, in response to the GA's required study of nurse to student ratios, adopted a recommended 1:750 ratio by 2014. The supporting documents used by the State Board in making their decision were developed and provided by the nurse consultants in the School Health Unit of the C&Y Branch. Continuing education for approximately 450 public health and school nurses was provided at the 20th Annual School Nurse Conference, entitled "School Health Then and Now." In addition the following workshops and conferences were held: two school nurse orientation workshops for 100 new school nurses and their supervisors, a physical assessment course, a school nurse certification review course, the School Mental Health Project consisting of 10 modules on a variety of mental health topics, and the Nursing Care of Children in Disasters and Public Health Emergencies course co-sponsored with NC's EMSC attended by more than 250 school nurses. School health services staff have participated in the development of the logic models for the C&Y Branch and for the School Health Matrix. In collaboration with the Standards and Best Practices Committee of the School Nurses Association of NC, (SNANC) the Student's Permanent Health Record was revised to include a place to record BMI.

**Figure 4b, State Performance Measures from the Annual Report Year Summary Sheet**

| Activities | Pyramid Level of Service | | | |
|---|---|---|---|---|
| | DHC | ES | PBS | IB |
| 1. Development of program agenda for Annual School Nurse Conference and other continuing ed offerings | | | | X |
| 2. Clinical and administrative consultation, training and TA to school districts, LHDs, and hospitals. | | | | X |
| 3. Collection and analysis of data regarding health needs, resources and program services. | | | | X |
| 4. Development of standards, guidelines and procedures. | | | | X |
| 5. Dissemination of new nursing and school health related information. | | | | X |
| 6. | | | | |
| 7. | | | | |
| 8. | | | | |
| 9. | | | | |
| 10. | | | | |

b. Current Activities

Data for the North Carolina Annual School Health Services Report for Public Schools for FY04 was summarized. As in previous years, this data was used to identify trends in student health needs and service delivery and to support recommendations for policies and increased staff. The Report was distributed to school nurses, to key decision-makers in state and local government and to advocates for school nursing/health across the state. The data was used to support the establishment of the School Nurse Funding Initiative (SNFI) by the General Assembly in July 2004. This Initiative funded 80 permanent and 65 two-year school nurse positions. This increased the number of local education agencies (LEAs) meeting the 1:750 nurse to student ratio from 10 to 24 and provided positions to the four LEAs who had been without a school nurse. In addition a one-time $5000 award was made to the 10 LEAs that already had the recommended 1:750 ratio. The FY04 state nurse to student ratio was 1:1897, which was still well short of the 1:1700 goal for this year. One of the requirements for the local health departments, school systems and hospitals receiving allocations under the SNFI was the

development of an action plan that describes the outcomes, activities and strategies that the nurse would employ in six basic health services areas. A report that addresses the over all progress toward meeting the outcomes and the accomplishments and challenges of the new position is to be submitted by each nurse by June 30, 2005. The six regional school nurse consultants worked very closely with the new nurses and their supervisors in the development of the action plans and continue to work within their regions to promote the development and expansion of school health services and other components of the Coordinated School Health Program. Continuing education opportunities for school nurses and other school health staff included the 21st Annual School Nurse Conference attended by approximately 500, four offerings of a two-day New School Nurse Orientation workshop (50 participants each workshop) where the regional consultants served as faculty, a Physical Assessment Course for School Nurses and a two-day School Nurse Certification Review Course.

### c. Plan for the Coming Year

Data from the School Nurse Survey and Program Summary for FY05 will be summarized in the North Carolina Annual School Health Services Report for Public Schools. As in previous years, this date will be used to identify trends in student needs and service delivery and to support recommendations for policies and increased staff. The Report will be distributed to school nurses and to key decision-makers in state and local government and will be used to advocate for school nursing/health across the state. The School Health Funding Initiative will move into its second year of activities. Findings from the first year's report of successes and challenges in providing basic health services will guide priority setting for the second year of outcome and activity development. The six regional school nurse consultants will continue to work within their regions to promote the development and expansion of school health services. Through the School Health Matrix, they will work closely with other staff affiliated with the Matrix to assist local school districts in the development of school health advisory councils and the implementation of tobacco free campuses and daily physical activity programs. The 22nd Annual School Nurse Conference entitled Getting Committed to Accountability will be held October 13-14, 2005 in Greensboro for approximately 550 school nurses and other school staff. The program will address a number of clinical and environmental issues affecting student health including mental health, communicable disease prevention, and the influence of media messages on teens. Three New School Nurse Orientation Workshops will be offered for nurses in their respective positions for less than one year. A newly developed Leadership Institute, designed by the school nurse consultants for school nurse supervisors and lead nurses, will be launched in early December. The school nurse consultants will continue to serve on a variety of state committees and task forces in order to promote interdisciplinary and interagency collaboration regarding school health programs. These committees include NC Asthma Alliance, NC Diabetes Advisory Council, SNANC Standards and Best Practices Committee, Clinical Mental Health Training Course for School Nurses, and the Tobacco Free Schools Task Force.

## E. OTHER PROGRAM ACTIVITIES

MCH Hotline - NC's Family Health Resource Line has evolved from a prenatal care hotline to a multi-program resource. The hotline averages 3,500-4,000 calls a month and operates during general office hours on weekdays. It offers bilingual and TTY services, and offers information, referral, and advocacy services.

In 1990, NC launched First Step, an infant mortality public awareness campaign, which included a statewide toll-free number. The line responded to calls related to preconceptional, prenatal, postpartum, and infant care; breastfeeding and nutrition; and Baby Love (Medicaid for pregnant women). In 1994, the Health Check Hotline (Medicaid for children) was launched. The line was co-located with the First Step Hotline, using the same staff but a separate toll-free number. With this

expansion, the hotline's mission broadened to encompass child health topics. That same year, the First Step Hotline added a focus on prenatal substance use prevention and treatment. In 1998, programs pooled resources to create the NC Family Health Resource Line. The state's Smart Start Program, a public-private initiative that provides early education funding to all of the state's counties, became a partner and contributed early child development and parenting resources, and the Health Choice Program (SCHIP) marketed the line as their "call to action" to learn more about free and low-cost health insurance. In 2002, the NC Child Care Health and Safety Resource Center was merged into the NC Family Health Resource Line, again expanding breadth of services and resources. The NC Family Health Resource Line is funded by state dollars, federal Medicaid matching dollars and MCH grant funds.

The Family Health Resource Line is now administered through the University of North Carolina at Chapel Hill. There are 12 individuals who staff the consolidated lines and the resource center. Families with young children who have developmental concerns or other special health care needs are linked to services directly and referred to the Title V CSHCN hotline and the Early Childhood (Part C) hotline, which is operated (but not funded) by Title V.

Targeted campaigns have increased public awareness of the line, most notably the "First Step" campaign to reduce infant mortality, "Back to Sleep" SIDS-prevention, "Veggies and Vitamins" birth defects prevention, and "Health Check/Health Choice" child health insurance campaign. As hotline administrators noted, the hotline must be continuously marketed to be effective.

Collaboration is a key strength of the NC Family Health Resource Line. The hotline is one of the few that has an advisory committee exclusively dedicated to oversight. Members of the committee include representatives from UNC-Chapel Hill, Title V, Medicaid, CSHCN, the resource line and other key lines. With the hiring of a full-time parent liaison in the C&Y Branch and her work with the Family Advisory Council, the resource line will have greater parental involvement.

The hotline also serves as a key policy tool in that it helps MCH staff identify populations served, the success or failure of outreach efforts, service gaps, and barrier issues. Frequently staff learn about programmatic issues from callers. For example, the state's SCHIP program initially had a 2-month uninsured waiting period. Through the hotline, staff learned that families of children with special needs were choosing to go without insurance to qualify for the more comprehensive, public health insurance. With this data, the program eliminated the uninsured waiting period.

The hotline also offers advocacy services beyond those typically offered, as it links families with medical assistance and resolves barrier issues. Through calls to the line, program staff can identify procedures that are not being implemented appropriately at the local level or by the insurance intermediary.

The NC Sudden Infant Death Syndrome (SIDS) Program is administered through the WHB. Grief counseling and support services are provided to families who have lost an infant to either suspected or confirmed SIDS by either a local or regional SIDS Counselor. Educational outreach and prevention awareness services are provided to health care providers, child care providers, community groups, and first responders. In FY99, the SIDS Program continued to expand its efforts to support primary prevention of SIDS deaths by promoting public awareness of the importance of proper infant sleep positioning. The campaign was designed to complement the national "Back to Sleep" campaign by ensuring access to national public education materials through the hotline and other local sources. A photo-novella targeting African American multigenerational families was developed and distributed which received very positive reviews.

## F. TECHNICAL ASSISTANCE

See Form 15 for specific technical assistance requests.

## V. BUDGET NARRATIVE

### A. EXPENDITURES

***/2006/ Total state partnership expenditures in 2004 were more than $20 million over 2003. The primary reasons for this were the inclusion of over $12 million in dental health services for children paid by the state Medicaid program in local health departments. These expenditures were not reported in 2003, so this is not necessarily a true increase in expenditures. Another major difference was the increased expenditure of infant formula rebates for recipients of WIC services. This was a true increase amounting to approximately $5 million. Expenditures of MCH Block Grant funds accounted for about $2 million of the total increase./2006/***

### B. BUDGET

/2004/The most significant change in North Carolina's MCH Block Grant budget/expenditure plan for FY02 was to change the way the state accounted for the federal funds and the required match, and secondly the way the federal funds were drawn from open awards. Before FY02, the state had budgeted/expended all the federal funds in unique cost centers that identified funds as 100% MCH Block Grant dollars. State funds used for MOE/match were budgeted and expended in different cost centers. This allowed the Title V agency to designate federal funds into program areas that would help maintain the 30%/30% requirements. However in FY02, the state required that all state match for the grant be budgeted in the same cost center with the relevant federal dollars. Upon expenditure of those pooled dollars, the state drew the appropriate number of federal dollars to reflect the 4:3 match rate. While this method assured the state of meeting the required match, it created a challenge for the agency to align budgets for supported programs to continue to meet the 30%/30% set asides. However, this was achieved and the attached table (FY03 MCH Block Grant Budget Justification by Program/Activity by Type of Service) reflects the distribution of Maternal and Child Health Block Grant funds anticipated in 03-04 according to the targeted programs.

A second change occurred in FY02 that was concurrent with the change in the accounting method. Before FY02, the expenditure of MCH Block Grant funds could be designated from particular awards. This practice led to large unobligated balances after the first year of an award, as expenditures were charged to the new grant at the time of the award. The state had to then designate unobligated funds for relevant maternal and child health projects to insure the expenditure of those funds in the second year of the budget period. In FY02, the state began expending funds from the earliest open grant award on a first in, first out basis. This assured the state that the full amount of the award would be expended by the end of the second year of the budget period.

The maintenance of effort from 1989 is $29,063,379. Total state funds budgeted for MCH programs as shown in Form 2 is $39,427,038. This includes state funds used for matching Title V funds, which, for the FY04 application, is $12,887,306.//2004//

/2005/The maintenance of effort from 1989 is $29,063,379. Total state funds budgeted for MCH programs as shown in Form 2 is $38,515,199. This includes state funds used for matching Title V funds, which, for the FY05 application, is $13,143,054.//2005//

***/2006/The maintenance of effort from 1989 is $29,063,379. Total state funds budgeted for MCH programs as shown in Form 2 is $41,825,405. This includes state funds used for matching Title V funds, which, for the FY06 application, is $13,077,417.***

***The attached table (FY06 MCH Block Grant Budget Allocation of Funds by Program/Activity by Type of Service) reflects the distribution of Maternal and Child Health Block Grant funds anticipated in 05-06 according to the targeted programs.//2006//***

## VI. REPORTING FORMS-GENERAL INFORMATION

Please refer to Forms 2-21, completed by the state as part of its online application.

## VII. PERFORMANCE AND OUTCOME MEASURE DETAIL SHEETS

For the National Performance Measures, detail sheets are provided as a part of the Guidance. States create one detail sheet for each state performance measure; to view these detail sheets please refer to Form 16 in the Forms section of the online application.

## VIII. GLOSSARY

A standard glossary is provided as a part of the Guidance; if the state has also provided a state-specific glossary, it will appear as an attachment to this section.

## IX. TECHNICAL NOTE

Please refer to Section IX of the Guidance.

## X. APPENDICES AND STATE SUPPORTING DOCUMENTS

### A. NEEDS ASSESSMENT

Please refer to Section II attachments, if provided.

### B. ALL REPORTING FORMS

Please refer to Forms 2-21 completed as part of the online application.

### C. ORGANIZATIONAL CHARTS AND ALL OTHER STATE SUPPORTING DOCUMENTS

Please refer to Section III, C "Organizational Structure".

### D. ANNUAL REPORT DATA

This requirement is fulfilled by the completion of the online narrative and forms; please refer to those sections.